

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 1-Film 406 10/28/68  
CERTIFICATE OF DEATH 14209 14218

1. DECEASED-NAME (Type or print) First <u>Gladys</u> Middle <u>YINGLING</u> Last <u>ABBOTT</u>			2a. DATE OF DEATH Month <u>10</u> Day <u>18</u> Year <u>68</u>			2b. HOUR <u>3:35</u> M					
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH <u>SEPT 24, 1904</u>		6. AGE (In years last birthday) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>CARROLL</u> Md.					
10. CITY OR TOWN OF DEATH <u>WESTMINSTER</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>CARROLL CO HOSPITAL</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>SEWING FACTORY</u>				12b. KIND OF BUSINESS OR INDUSTRY <u>SEWING</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u>		13b. COUNTY <u>CARROLL</u>		13c. CITY OR TOWN <u>UNION BRIDGE</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>MAIN ST.</u>			
14. FATHER'S NAME First <u>WILLIAM</u> Middle <u>YINGLING</u> Last <u>MOSS</u>			15. MOTHER'S MAIDEN NAME First <u>MOLLIE</u> Middle <u>SMITH</u> Last <u>SMITH</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>213-18-8701</u>		17. INFORMANT <u>PATRICIA WILLIAMS</u>		Address <u>RURAL WESTMINSTER MD</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MASSIVE GASTROINTESTINAL HEMORRAGE</u> <u>157.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMA OF THE PANCREAS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>8 mo.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>72 HOURS</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>157X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>10/13, 1968</u> , to <u>10/18, 1968</u> , that (I) (we) lost saw the deceased alive on <u>10/18, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Vincent J. Fiocco</u>					22c. DATE SIGNED <u>10/18/68</u>		22d. PHYSICIAN'S NAME (Type) <u>VINCENT J. FIOCCO</u>				
22e. ADDRESS <u>WESTMINSTER MD</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>10/21/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		23d. LOCATION (City or Town) (County) (State) <u>UNION TOWN MD</u>					
24. FUNERAL DIRECTOR <u>D N Hartzler &amp; Sons Union Bridge MD</u>					25a. REC'D BY REGISTRAR <u>OCT 22 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>				

14507  
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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 14210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14219

1. DECEASED-NAME (Type or Print) <b>JOHN WARFIELD ALLGIRE</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>2:00</b> P.M.	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 10, 1916</b>	6. AGE (In years last birthday) <b>52</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>25</b> Year <b>1968</b>	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>	
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Rt. 4</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME First <b>H. Walter</b> Middle <b>Allgire</b> Last <b>Allgire</b>			15. MOTHER'S MAIDEN NAME First <b>Amanda</b> Middle <b>Leppo</b> Last <b>Leppo</b>			13e. STREET AND NUMBER <b>Rt. 4</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT ADDRESS <b>Herbert Allgire Hampstead, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>William Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10/25/68</b>	
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS Street, City or Town, County <b>1556 Main Westminster Carroll</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wesley Cemetery</b>		23d. LOCATION (City or Town) (County) <b>Hampstead, Carroll Co. Md.</b>	
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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WOMEN'S BUILDING

1911

WOMEN'S BUILDING

July 1, 1911

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Building

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14212									
14220									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
IVY			ROSELLA ARBAUGH			Month Day Year OCT. 27 68			4:30 M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
FEMALE		WHITE		APRIL 29 1875		93 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
MARYLAND		U.S.A.				CARROLL			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER		R.F.D. #2			HOUSE-WIFE				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MARYLAND		CARROLL		WESTMINSTER				R.F.D. #2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
GRANVILLE COPPERSMITH			SUSAN MYERS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
NO			?		GRANVILLE J. ARBAUGH		SAME ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Acute Pulmonary edema									1 day
DUE TO, OR AS A CONSEQUENCE OF									
(b) C.A.F.									1 wk.
DUE TO, OR AS A CONSEQUENCE OF									
(c) Diabetes arteriosclerosis									20 yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
260X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from MAY, 1967, to OCT 27, 1968, that (I) (we) last saw the deceased alive on OCT 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED
DONALD A. KNIGHT M.D.									10/30/68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
DONALD A. KNIGHT M.D.					GREENMOUNT, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10/30/68		MEADOW BRANCH CEM		WESTMINSTER MD.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J.E. Smyers, Westminster, Md.					DATE NOV 6 1968		Charles Judge		

14330

RECEIVED BY STATE

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NOV 1 1961

14212

## CERTIFICATE OF DEATH

14221

1. DECEASED-NAME (Type or print) <b>GEORGE CURTIS BABCOCK</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>3</b> Year <b>68</b>			2b. HOUR <b>5:30 A.M.</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOV 17, 1890</b>		6. AGE (In years last birthday) <b>77</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b> Md.	
10. CITY OR TOWN OF DEATH <b>NEW WINDSOR, MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HORTON BOARDING HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>ELECTRICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>EXETER ROAD</b>		14. FATHER'S NAME First <b>ELMER</b> Middle <b>BABCOCK</b> Last <b>BABCOCK</b>		15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>McGINNIS</b> Last <b>McGINNIS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>YES</b> (If yes give war or dates of service) <b>WWI</b>	
16b. SOCIAL SECURITY NO. <b>217-18-8717</b>		17. INFORMANT <b>MRS. LYDIA N. BABCOCK</b>		Address <b>EXETER ROAD WESTMINSTER, MD.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic C.V.D.</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4221</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/68</b> , 19 <b>68</b> , to <b>10/3/68</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/11/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>M.E. Robertson M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>M.E. ROBERTSON M.D.</b>		22e. ADDRESS <b>New Windsor, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/5/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER CARROLL, MD</b>	
24. FUNERAL DIRECTOR <b>J.S. Myers, Jr., Westminster, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14331

CERTIFICATE OF DEATH

1901

(M)

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Handwritten notes in the left margin, possibly including a date and other details.

1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14222	
14213										CERTIFICATE OF DEATH	
1. DECEASED-NAME (Type or print) First Middle Last WILLIAM H. H. BARNES					2a. DATE OF DEATH 10 Month 4 Day 68 Year			2b. HOUR 8 A.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Sept. 27, 1885			6. AGE (In years lost birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Route 2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer (Retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Route 2			
14. FATHER'S NAME First Middle Last James A. Barnes					15. MOTHER'S MAIDEN NAME First Middle Last Maggie English						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 417-36-4259		17. INFORMANT Address W. Herman Barnes R.D.2, Mt. Airy, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 424.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Embolus from endocardium</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive heart failure (valvular heart disease)</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 hour 10 years or so											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4214											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-19</u> , 19 <u>67</u> , to <u>10-4</u> , 19 <u>68</u> , that (I) (we) lost the deceased on <u>10-1</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Julius Chepko</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/4/68				
22d. PHYSICIAN'S NAME (Type) <u>Julius Chepko M.D.</u>					22e. ADDRESS <u>Est. W. Green St. Westminster, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/7/1968		23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION (City or Town) (County) (State) Taylorsville, Carroll, Md.					
24. FUNERAL DIRECTOR ADDRESS C. M. Waltz, Box 241, Sykesville, Md.					25a. REC'D BY REGISTRAR DATE OCT 8 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				



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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14214 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH			2b. HOUR		
First Middle Lost Agnes Christina Bartosh					10 Month 21 Day 68 Year			9:25 am		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
female		white		3/10/98		70 YRS.		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Lithuania		Lithuania				Carroll				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Rural--Sykesville		Springfield State Hosp.		housewife		at home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.				Baltimore				2926 Harford Road		
14. FATHER'S NAME First Middle Lost			15. MOTHER'S MAIDEN NAME First Middle Lost							
John ? Krivickas			Tina ?							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			216-32-9610		Springfield Hospital records, Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute suppurative nephritis and pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days & weeks Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>7/10/1963</u> , to <u>10/21/1968</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>10/21/1968</u> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death.										
22b. SIGNATURE <u>Renato R. Espina</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/21/68			
22d. PHYSICIAN'S NAME (Type) Renato R. Espina, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10/24/68		Landon Park Cemo.		3801 Midwick Ave Md.				
24. FUNERAL DIRECTOR <u>John J. Korman &amp; Son Inc.</u>					ADDRESS 901 Hollins St.		25a. REC'D BY REGISTRAR DATE OCT 23 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

145233

RECEIVED 10-10-1961

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14215

CERTIFICATE OF DEATH

14224

1. DECEASED-NAME (Type or print) First Middle Last EMMA SARAH BAU			2a. DATE OF DEATH Month Day Year October 22 1968			2b. HOUR 1:25 P M	
3. SEX F		4. RACE W		5. DATE OF BIRTH NOV 7-1877		6. AGE (In years last birthday) 90 YRS.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.	
10. CITY OR TOWN OF DEATH MIDDLEBURG		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) BROOKFIELD NURSING HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEKEEPER		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN NEW WINDSOR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 305 COLLEGE AVE		14. FATHER'S NAME First Middle Last HENRY SPIELMAN		15. MOTHER'S MAIDEN NAME First Middle Last AMELIA SITTIG		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO	
16b. SOCIAL SECURITY NO. 214-22-1031		17. INFORMANT JANE COALE		Address RURAL TANEYTOWN MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> 437.9 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 28 days years
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/25</u> , 19 <u>68</u> , to <u>Now</u> , 19 <u>  </u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>10/22/68</u> 19 <u>  </u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death.							
22b. SIGNATURE J H Caricofe MD		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/22/68	
22d. PHYSICIAN'S NAME (Type) J H CARICOFE		22e. ADDRESS UNION BRIDGE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 10/24/68		23c. NAME OF CEMETERY OR CREMATORY WINTERS		23d. LOCATION (City or Town) (County) (State) NEW WINDSOR RURAL MD	
24. FUNERAL DIRECTOR D D Fentler & Sons		ADDRESS New Windsor		25a. REC'D BY REGISTRAR DATE OCT 25 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14216 CERTIFICATE OF DEATH 14225									
1. DECEASED-NAME (Type or print) First Middle Last Mary E. Bennett			2a. DATE OF DEATH Month Day Year Oct 26 1968			2b. HOUR 1:10A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH Sept. 6, 1882		6. AGE (In years last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Union Mills		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Meadow View Nursing Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Pants Factory			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D.	
14. FATHER'S NAME First Middle Last Theophus Magers			15. MOTHER'S MAIDEN NAME First Middle Last Mary E. Harris						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 215-03-6151		17. INFORMANT Address Mrs. Addie Porter, Rt. 2, Mt. Airy, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> 174X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma left breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 170 MONTH 1 year									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 170X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 170X		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5/27, 1968, to 10/26, 1968, that (I) (we) last saw the deceased alive on 10/22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Julius Chopko M.D.				22c. DATE SIGNED 10/27/68		22d. PHYSICIAN'S NAME (Type) Julius Chopko			
22e. ADDRESS 85 1/2 W. Green St Westminster Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/29/1968		23c. NAME OF CEMETERY Pine Grove		23d. LOCATION (City or Town) (County) (State) Mt. Airy, Carroll, Md.			
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR DATE OCT 30 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

14328

STATEMENT OF DEATH

1931

14328

*[Faint, mostly illegible text from a form, possibly containing names, dates, and addresses.]*

1931

14217

CERTIFICATE OF DEATH

14226

1. DECEASED-NAME (Type or print) <b>Mildred Lillian Bowen</b>			2a. DATE OF DEATH Month <b>Oct.</b> Day <b>29</b> Year <b>1968</b>		2b. HOUR <b>3 a.m.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 14, 1922</b>		6. AGE (In years last birthday) <b>46</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>
10. CITY OR TOWN OF DEATH <b>Woodbine</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 97</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Woodbine</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Route 97</b>
14. FATHER'S NAME First <b>Edward</b> Middle <b>-</b> Last <b>Martin</b>			15. MOTHER'S MAIDEN NAME First <b>Lillian</b> Middle <b>-</b> Last <b>-</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mr. Levering Bowen, Jr. Woodbine, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Brain Disease</b> <b>1533</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>C.A. of Sigmoid Colon</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>1533</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug. 1</b> , 19 <b>68</b> , to <b>Oct. 29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Naci N. Buyukunsal, M.D.</b>				22c. DATE SIGNED <b>10/30/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M.D.</b>				22e. ADDRESS <b>Obrecht Rd., Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-31-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>David Ridge Cemetery</b>	
24. FUNERAL DIRECTOR <b>Harry Wren Haight</b>		ADDRESS <b>Sykesville, Md.</b>		23d. LOCATION (City or Town) (County) (State) <b>Sykesville Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14320

REPUBLIC OF CHINA

1951



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
2  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14218

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14227

1. DECEASED NAME (Type or print) First Middle Last Benjamin NMM Brown			2a. DATE OF DEATH Month Day Year 10 11 68			2b. HOUR 1:15 P M			
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH 11-1-1887		6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Unknown		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) laborer		12b. KIND OF BUSINESS OR INDUSTRY Unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 3742 Boarman Avenue, Balt.Md.	
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Florence Unk. Unk.						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. 212-24-7721A		17. INFORMANT Hospital Records		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis-Myocardial infarction</u> 4709 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 <u>Chronic Brain Syndrome ass. with senile brain disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>68</u> , to <u>10-11</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10-11</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Suha Ozgun				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-11-68			
22d. PHYSICIAN'S NAME (Type) Suha Ozgun				22e. ADDRESS Springfield State Hospital, Sykesv., Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/18/68		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore Md			
24. FUNERAL DIRECTOR Adolphus Halstead 1206 W 14 North Ave				25a. REC'D BY REGISTRAR DATE OCT 17 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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10/18/68

10/18/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 74 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14219

## CERTIFICATE OF DEATH

14228

1. DECEASED-NAME: (Type or print) <b>Cornelia Sue Brown</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>8:30</b> P.M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 22, 1888</b>		6. AGE (In years lost birthday) <b>80</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>VA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Oklahoma Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>Oklahoma Road</b>		14. FATHER'S NAME First <b>Frank</b> Middle <b>Johnson</b> Last <b>Johnson</b>		15. MOTHER'S MAIDEN NAME First <b>—</b> Middle <b>—</b> Last <b>Warfield</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mr. Robert Brown</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LEFT VENTRICULAR FAILURE</b>							<b>1 day.</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.C.V. disease</b>							<b>10 yrs.</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Some osteoarthritis</b>							<b>20 yrs.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 22, 1968</b> to <b>10-23, 1968</b> , that (I) (we) last saw the deceased alive on <b>10-22, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R.V. Houck Jr. M.D.</b>				22c. DATE SIGNED <b>10-23-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>R.V. Houck Jr. MD.</b>				22e. ADDRESS <b>Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Oakland</b>		23d. LOCATION (City or Town) (County) (State) <b>Sykesville Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Haight</b>				25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	

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## CERTIFICATE OF DEATH

14229

1. DECEASED-NAME (Type or print) <b>GERTRUDE ALICE BROWN</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>15</b> Year <b>68</b>			2b. HOUR <b>11:25</b> PM	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MAY 17, 1921</b>		6. AGE (In years last birthday) <b>47</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GEN. HOSP. CLOTHING AND SHOE FACTORIES</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>96 W. MAIN ST</b>		14. FATHER'S NAME First <b>CHARLES H.</b> Middle <b>BROWN</b> Last <b>BROWN</b>		15. MOTHER'S MAIDEN NAME First <b>LOTTIE</b> Middle <b>GROFT</b> Last <b>GROFT</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service) <b>-</b>	
16b. SOCIAL SECURITY NO. <b>219-01-2092</b>		17. INFORMANT <b>MRS MARGARET B. HERSHEY</b>		Address <b>26 WEBSTER WESTMINSTER</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SEPTICEMIA</b> <b>2509</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>DIABETIC NEPHROPATHY</b> <b>260X</b> <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b> <b>WEEKS</b> <b>YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1964</b> , to <b>10/15/68</b> , that (I) (we) last saw the deceased alive on <b>10/15/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles J. Judge</b>				22c. DATE SIGNED <b>10/15/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Charles J. Judge</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT. 18, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEMETERY WESTMINSTER MD.</b>		23d. LOCATION (City or Town) (County) (State) <b>MD.</b>	
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr., Westminster, Md.</b>				25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14222					14230				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
Lillie C BRUCE					October 28 1968 1:30 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		Nov 9 1874		93		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Carroll Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Manchester Md.		Largo Baltimore 128 W MAIN		Housewife		Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Lanham Pa		Lancaster		Quarryville				Church Street	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
First Middle Last		First Middle Last							
Samuel		Emma		Rittenhouse					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address					
No		None		Mrs Emma J. Zander Sparks Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Chronic Myocarditis									
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4221 Myocardial Ischemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> (If either, notify medical examiner)		21b. TIME OF INJURY HOUR AM Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-7-63, 1963 to 10-28, 1968, that (I) (we) last saw the deceased alive on 10-27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Joseph E. Bush MD		10-28-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Joseph E. Bush MD		Hampstead Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Oct. 30, 1968		New Providence Reformed Ch		New Providence Lancaster, Co. Pa			
24. FUNERAL DIRECTOR		Address		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Paul Kynobly		236 Quarryville, Pa		OCT 30 1968		Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit must be removed from the pages, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14222

CERTIFICATE OF DEATH

14231

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
WILFRED			PATRICK	CAMPBELL	OCTOBER 9, 1968			7:20A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 6-27-07		6. AGE (In years lost birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Security Guard (retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 13300 Okinawa Avenue			
14. FATHER'S NAME John			First	Middle	Lost	15. MOTHER'S MAIDEN NAME Elizabeth Regan			First Middle Lost XMK.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 322-22-0827		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral bronchopneumonia</u> <u>485X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>491X</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-30-68</u> , 19____, to <u>10-9-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>10-9-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Octavio A. Ruiz, M.D.</u>		DEGREE		ATTENDING PHYS.		<input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-9-68			
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/12/68		23c. NAME OF CEMETERY OR CREMATORY Parklawn		23d. LOCATION (City or Town) (County) (State) Rockville, Montg. Maryland					
24. FUNERAL DIRECTOR Tyson Wheeler		ADDRESS Funeral Home 1331 Rock Pike Rockville, Maryland		25a. REC'D BY REGISTRAR DATE OCT 14 1968		25b. REGISTRAR'S SIGNATURE f Charles Judge					

14831

RECEIVED 10 JAN 1950

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14223 CERTIFICATE OF DEATH 14232										
1. DECEASED-NAME (Type or print) <b>ACE</b>			First Middle Last <b>ANDERSON CHILDERS</b>			2a. DATE OF DEATH Month Day Year <b>10 29 68</b>			2b. HOUR P <b>2:00 M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>08/10/95</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>plasterer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>203 Lee Street</b>	
14. FATHER'S NAME First Middle Last <b>Robert Childers</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Susan Virginia Carder</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>220-05-8951</b>		17. INFORMANT Address <b>Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4409</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4500</b> (b) <b>Osteomyelitis right foot</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>generalized arteriosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b> <b>years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>CBS assoc. with brain trauma, gross force, without qualifying phrase</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from <b>9/16/60</b> , to <b>10/29/68</b> , that (X) (we) lost the deceased alive on <b>10/29/68</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Milton H. Buschman, MD</b>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/29/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Milton H. Buschman, M. D.</b>					22e. ADDRESS <b>Springfield State Hospital, Sykes., Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-1-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>			23d. LOCATION (City or Town) (County) (State) <b>Rockville, Montg., Md.</b>			
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b>					ADDRESS <b>Ernest C. Gartner</b>		25a. RECEIVED BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18 14224

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14233

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR				
ALBERT THOMPSON COUMBE						OCTOBER 18, 1968			7:14 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS				
Male		White		8-24-1888			80		YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Virginia		U.S.A.					Carroll			Md.			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN		
Springfield State Hospital		Assoc. Economic Analyst (Retired)			Govt. S.S. Md.			Maryland			Montgomery		
13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8016 Piney Branch Road			Albert Thompson Coumbe Sr.			Alice Ives			No		
16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19a. DATE OF OPERATION		
220-44-3202-T		Madeline M. Coumbe Records, Springfield State Hospital S.S. Md.			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus, left lung, with multiple lung abscesses</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Thrombophlebitis, left iliac vein</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adenocarcinoma of descending colon with metastases</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1532			Days or Wk. Weeks Months			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		
19c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY		
		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									HOUR A.M. Month Day Year P.M. 19		
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			22a. I certify that (H) (this hospital) attended the deceased from 9-2-68, 19, to 10-18-68, 19, that (U) (we) lost saw the deceased alive on 10-18-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.			22b. SIGNATURE		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					Street or R.F.D. No. City or Town County State						Paul G. Ensor, M. D.		
22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS			22f. REGISTRAR'S SIGNATURE			22g. REGISTRAR'S SIGNATURE		
15 OCT 1968		Paul G. Ensor, M. D.			Springfield State Hospital Sykesville, Maryland 21784			Warner E. Humphrey, Inc. 8434 Ga. Ave.			OCT 23 1968		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			23e. ADDRESS		
Burial		10-22-1968			Congressional Cemetery			Washington, D.C.			Sil. Spr. Md.		
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			25c. REGISTRAR'S SIGNATURE			25d. REGISTRAR'S SIGNATURE		
Warner E. Humphrey, Inc. 8434 Ga. Ave.		OCT 23 1968			OCT 23 1968			OCT 23 1968			OCT 23 1968		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

14225

14234

1. DECEASED-NAME (Type or print) <b>MILLARD W. CUMMINGS</b>				2a. DATE OF DEATH Month <b>10</b> Day <b>17</b> Year <b>68</b>				2b. HOUR <b>6:07</b> M	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-13-10</b>		6. AGE (In years last birthday) <b>58</b> YRS.		IF UNDER 1 YEAR MONTHS <b>58</b> DAYS <b>58</b> HOURS <b>58</b> MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll County General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Const.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>md</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Lineboro</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First <b>Wm</b> Middle <b>J.</b> Last <b>Cummings</b>		15. MOTHER'S MAIDEN NAME First <b>Maudie</b> Middle <b>L.</b> Last <b>Miller</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-12-7321</b>		17. INFORMANT <b>Strahl</b> Address <b>Cummings, Lineboro, Md. 21088</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RUPTURED ABDOMINAL AORTIC</b> <b>4412</b> DUE TO, OR AS A CONSEQUENCE OF <b>ANEURYSM</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>12 HOURS</b> <b>YEARS</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>451X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/17, 1968</b> , to <b>10/17, 1968</b> , that (I) (we) last saw the deceased alive on <b>10/17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Frederic J. Brown MD</b>				22c. DATE SIGNED <b>10/17/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Frederic J. Brown MD</b>			
22e. ADDRESS									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE <b>10/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Vernon Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>White Hall, Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>James J. Hartenstein</b>		ADDRESS <b>New Freedom, Pa.</b>		25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

1453

2524

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>14226</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>14235</div> </div>									
1. DECEASED-NAME (Type or Print) <b>PEGGY LOUISE DE HOFF</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>2</b> Year <b>1968</b>		2b. HOUR <b>?</b> MIN <b>?</b>	
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>10-25-36</b>	6. AGE (In years last birthday) <b>31</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS HOURS <b></b> MIN <b></b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>2</b> Year <b>1968</b>		2d. HOUR <b>2:40</b> MIN <b>P</b>	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>			
10. CITY OR TOWN OF DEATH <b>SYKESVILLE</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>ROUTE 4, SYKESVILLE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>SECRETARY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>P.B. &amp; C.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>SYKESVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RT 4 - SYKESVILLE</b>	
14. FATHER'S NAME First <b>EARL</b> Middle <b>-</b> Last <b>DE HOFF</b>			15. MOTHER'S MAIDEN NAME First <b>MARIE</b> Middle <b>T.</b> Last <b>HODGES</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>220 36 5031</b>		17. INFORMANT <b>MRS LAWRENCE GORE - ABOVE</b>		ADDRESS <b>MOTHER.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sunshot Wound Left Chest</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF <b>Self Inflicted</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>22 cal</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>976X</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>10-2</b> P.M. <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, or Part 3) <b>Impaled by rifle gun to chest &amp; pulled trigger</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home Lawrence</b>		21f. LOCATION Street or R.F.D. No. <b>Rd 4</b> City or Town <b>Sykesville</b> County <b>Carroll</b> State <b>MD</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-2-68</b>			
EXAMINER'S NAME (Type) <b>W. GLENN SPEICHER</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS <b>155 S. Street, Snow Hill, Westminster, Carroll, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-5-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom</b>		23d. LOCATION (City or Town) (County) (State) <b>Sykesville Carroll, Md</b>			
24. FUNERAL DIRECTOR <b>Arthur H. Haight</b>				ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



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UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14227

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14236

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR PM		
GOLDIE			PEARL		DESHONG	OCTOBER 1, 1968			10 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH 1-15-1900		6. AGE (In years last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.					
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Allegheny		13c. CITY OR TOWN Cumberland		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 228 N. Mechanic St.		
14. FATHER'S NAME First Middle Last Lawson G. Reynolds			15. MOTHER'S MAIDEN NAME First Middle Last Bertha Twigg								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215-26-6388		17. INFORMANT Address Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia and terminal uremia</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>443x</u> (b) <u>Chronic glomerulonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive arteriosclerotic heart disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Months Years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-24-65</u> , 19__, to <u>10-1-68</u> , 19__, that (I) (we) last saw the deceased alive on <u>10-1-68</u> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul G. Ensor, M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-1-68</u>			
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE <u>10/4/1968</u>		23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park			23d. LOCATION (City or Town) (County) (State) Near Cumberland Alleg Md.			
24. FUNERAL DIRECTOR <u>John J. Hafer, Jr.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 4 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

14200

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CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14228		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14237	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Lost	2a. DATE OF DEATH		2b. HOUR
Franklin Eugene Eyer					Month Day Year October 28 1968		8:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS
Male		White		August 12, 1912		56 YRS.	IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Carroll County Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Near Taneytown		Carroll Co. General Hosp.		Service Station Oper.		Gas Station	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Carroll		Taneytown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	
David Eyer		Maggie Shriner		No		199-07-4882	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
Mrs. June Eyer, Taney Dr., Taneytown, Md.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Minutes 6 years 6 years	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY	
21i. STATE		21j. STREET OR R.F.D. No.		21k. CITY OR TOWN		21l. COUNTY	
21m. STATE		21n. STREET OR R.F.D. No.		21o. CITY OR TOWN		21p. COUNTY	
21q. STATE		21r. STREET OR R.F.D. No.		21s. CITY OR TOWN		21t. COUNTY	
21u. STATE		21v. STREET OR R.F.D. No.		21w. CITY OR TOWN		21x. COUNTY	
21y. STATE		21z. STREET OR R.F.D. No.		21aa. CITY OR TOWN		21ab. COUNTY	
21ac. STATE		21ad. STREET OR R.F.D. No.		21ae. CITY OR TOWN		21af. COUNTY	
21ag. STATE		21ah. STREET OR R.F.D. No.		21ai. CITY OR TOWN		21aj. COUNTY	
21ak. STATE		21al. STREET OR R.F.D. No.		21am. CITY OR TOWN		21an. COUNTY	
21ao. STATE		21ap. STREET OR R.F.D. No.		21aq. CITY OR TOWN		21ar. COUNTY	
21as. STATE		21at. STREET OR R.F.D. No.		21au. CITY OR TOWN		21av. COUNTY	
21aw. STATE		21ax. STREET OR R.F.D. No.		21ay. CITY OR TOWN		21az. COUNTY	
21ba. STATE		21bb. STREET OR R.F.D. No.		21bc. CITY OR TOWN		21bd. COUNTY	
21be. STATE		21bf. STREET OR R.F.D. No.		21bg. CITY OR TOWN		21bh. COUNTY	
21bi. STATE		21bj. STREET OR R.F.D. No.		21bk. CITY OR TOWN		21bl. COUNTY	
21bm. STATE		21bn. STREET OR R.F.D. No.		21bo. CITY OR TOWN		21bp. COUNTY	
21bq. STATE		21br. STREET OR R.F.D. No.		21bs. CITY OR TOWN		21bt. COUNTY	
21bu. STATE		21bv. STREET OR R.F.D. No.		21bu. CITY OR TOWN		21bw. COUNTY	
21bx. STATE		21by. STREET OR R.F.D. No.		21bx. CITY OR TOWN		21bz. COUNTY	
21ca. STATE		21cb. STREET OR R.F.D. No.		21cc. CITY OR TOWN		21cd. COUNTY	
21ce. STATE		21cf. STREET OR R.F.D. No.		21ce. CITY OR TOWN		21cf. COUNTY	
21cg. STATE		21ch. STREET OR R.F.D. No.		21cg. CITY OR TOWN		21ch. COUNTY	
21ci. STATE		21cj. STREET OR R.F.D. No.		21ci. CITY OR TOWN		21cj. COUNTY	
21ck. STATE		21cl. STREET OR R.F.D. No.		21ck. CITY OR TOWN		21cl. COUNTY	
21cm. STATE		21cn. STREET OR R.F.D. No.		21cm. CITY OR TOWN		21cn. COUNTY	
21co. STATE		21cp. STREET OR R.F.D. No.		21co. CITY OR TOWN		21cp. COUNTY	
21cq. STATE		21cr. STREET OR R.F.D. No.		21cq. CITY OR TOWN		21cr. COUNTY	
21cs. STATE		21ct. STREET OR R.F.D. No.		21cs. CITY OR TOWN		21ct. COUNTY	
21cu. STATE		21cv. STREET OR R.F.D. No.		21cu. CITY OR TOWN		21cv. COUNTY	
21cw. STATE		21cx. STREET OR R.F.D. No.		21cw. CITY OR TOWN		21cx. COUNTY	
21cy. STATE		21cz. STREET OR R.F.D. No.		21cy. CITY OR TOWN		21cz. COUNTY	
21da. STATE		21db. STREET OR R.F.D. No.		21da. CITY OR TOWN		21db. COUNTY	
21dc. STATE		21dd. STREET OR R.F.D. No.		21dc. CITY OR TOWN		21dd. COUNTY	
21de. STATE		21de. STREET OR R.F.D. No.		21de. CITY OR TOWN		21de. COUNTY	
21df. STATE		21df. STREET OR R.F.D. No.		21df. CITY OR TOWN		21df. COUNTY	
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21dh. STATE		21dh. STREET OR R.F.D. No.		21dh. CITY OR TOWN		21dh. COUNTY	
21di. STATE		21di. STREET OR R.F.D. No.		21di. CITY OR TOWN		21di. COUNTY	
21dj. STATE		21dj. STREET OR R.F.D. No.		21dj. CITY OR TOWN		21dj. COUNTY	
21dk. STATE		21dk. STREET OR R.F.D. No.		21dk. CITY OR TOWN		21dk. COUNTY	
21dl. STATE		21dl. STREET OR R.F.D. No.		21dl. CITY OR TOWN		21dl. COUNTY	
21dm. STATE		21dm. STREET OR R.F.D. No.		21dm. CITY OR TOWN		21dm. COUNTY	
21dn. STATE		21dn. STREET OR R.F.D. No.		21dn. CITY OR TOWN		21dn. COUNTY	
21do. STATE		21do. STREET OR R.F.D. No.		21do. CITY OR TOWN		21do. COUNTY	
21dp. STATE		21dp. STREET OR R.F.D. No.		21dp. CITY OR TOWN		21dp. COUNTY	
21dq. STATE		21dq. STREET OR R.F.D. No.		21dq. CITY OR TOWN		21dq. COUNTY	
21dr. STATE		21dr. STREET OR R.F.D. No.		21dr. CITY OR TOWN		21dr. COUNTY	
21ds. STATE		21ds. STREET OR R.F.D. No.		21ds. CITY OR TOWN		21ds. COUNTY	
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21fr. STATE		21fr. STREET OR R.F.D. No.		21fr. CITY OR TOWN		21fr. COUNTY	
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21fy. STATE		21fy. STREET OR R.F.D. No.		21fy. CITY OR TOWN		21fy. COUNTY	
21fz. STATE		21fz. STREET OR R.F.D. No.		21fz. CITY OR TOWN		21fz. COUNTY	
21ga. STATE		21ga. STREET OR R.F.D. No.		21ga. CITY OR TOWN		21ga. COUNTY	
21gb. STATE		21gb. STREET OR R.F.D. No.		21gb. CITY OR TOWN		21gb. COUNTY	
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21gk. STATE		21gk. STREET OR R.F.D. No.		21gk. CITY OR TOWN		21gk. COUNTY	
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21gn. STATE		21gn. STREET OR R.F.D. No.		21gn. CITY OR TOWN		21gn. COUNTY	
21go. STATE		21go. STREET OR R.F.D. No.		21go. CITY OR TOWN		21go. COUNTY	
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21gq. STATE		21gq. STREET OR R.F.D. No.		21gq. CITY OR TOWN		21gq. COUNTY	
21gr. STATE		21gr. STREET OR R.F.D. No.		21gr. CITY OR TOWN		21gr. COUNTY	
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21gu. STATE		21gu. STREET OR R.F.D. No.		21gu. CITY OR TOWN		21gu. COUNTY	
21gv. STATE		21gv. STREET OR R.F.D. No.		21gv. CITY OR TOWN		21gv. COUNTY	
21gw. STATE		21gw. STREET OR R.F.D. No.		21gw. CITY OR TOWN		21gw. COUNTY	
21gx. STATE		21gx. STREET OR R.F.D. No.		21gx. CITY OR TOWN		21gx. COUNTY	
21gy. STATE		21gy. STREET OR R.F.D. No.		21gy. CITY OR TOWN		21gy. COUNTY	
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21ha. STATE		21ha. STREET OR R.F.D. No.		21ha. CITY OR TOWN		21ha. COUNTY	
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21hf. STATE		21hf. STREET OR R.F.D. No.		21hf. CITY OR TOWN		21hf. COUNTY	
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21hj. STATE		21hj. STREET OR R.F.D. No.		21hj. CITY OR TOWN		21hj. COUNTY	
21hk. STATE		21hk. STREET OR R.F.D. No.		21hk. CITY OR TOWN		21hk. COUNTY	
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21hm. STATE		21hm. STREET OR R.F.D. No.		21hm. CITY OR TOWN		21hm. COUNTY	
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21ho. STATE		21ho. STREET OR R.F.D. No.		21ho. CITY OR TOWN		21ho. COUNTY	
21hp. STATE		21hp. STREET OR R.F.D. No.		21hp. CITY OR TOWN		21hp. COUNTY	
21hq. STATE		21hq. STREET OR R.F.D. No.		21hq. CITY OR TOWN		21hq. COUNTY	
21hr. STATE		21hr. STREET OR R.F.D. No.		21hr. CITY OR TOWN		21hr. COUNTY	
21hs. STATE		21hs. STREET OR R.F.D. No.		21hs. CITY OR TOWN		21hs. COUNTY	
21ht. STATE		21ht. STREET OR R.F.D. No.		21ht. CITY OR TOWN		21ht. COUNTY	
21hu. STATE		21hu. STREET OR R.F.D. No.		21hu. CITY OR TOWN		21hu. COUNTY	
21hv. STATE		21hv. STREET OR R.F.D. No.		21hv. CITY OR TOWN		21hv. COUNTY	
21hw. STATE		21hw. STREET OR R.F.D. No.		21hw. CITY OR TOWN		21hw. COUNTY	
21hx. STATE		21hx. STREET OR R.F.D. No.		21hx. CITY OR TOWN		21hx. COUNTY	
21hy. STATE		21hy. STREET OR R.F.D. No.		21hy. CITY OR TOWN		21hy. COUNTY	
21hz. STATE		21hz. STREET OR R.F.D. No.		21hz. CITY OR TOWN		21hz. COUNTY	
21ia. STATE		21ia. STREET OR R.F.D. No.		21ia. CITY OR TOWN		21ia. COUNTY	
21ib. STATE		21ib. STREET OR R.F.D. No.		21ib. CITY OR TOWN		21ib. COUNTY	
21ic. STATE		21ic. STREET OR R.F.D. No.		21ic. CITY OR TOWN		21ic. COUNTY	
21id. STATE		21id. STREET OR R.F.D. No.		21id. CITY OR TOWN			

14537

14537

RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

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U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

RECEIVED  
JAN 10 1908  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

14229

14238

1. DECEASED NAME (Type or print)		First MYRLE		Middle E.		Last FARVER		2a. DATE OF DEATH		Month 10		Day 10		Year 68		2b. HOUR 6:45 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH March 7, 1888				6. AGE (In years last birthday) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN					
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.											
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse - Retired				12b. KIND OF BUSINESS OR INDUSTRY									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Church Street									
14. FATHER'S NAME First Harry		Middle E.		Last Koontz		15. MOTHER'S MAIDEN NAME First Caroline		Middle E.		Last Alexander							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 215-48-6183		17. INFORMANT Mrs. Louise Franklin		Address Rt. 2, Mt. Airy, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMOCOCCAL MENINGITIS</u> <u>3201</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 DAYS</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>3401</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/12</u> , 1968, to <u>10/10</u> , 1968, that (I) (we) last saw the deceased alive on <u>10/10</u> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Vincent J. Fiocco MD</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <u>10/10/68</u>					
22d. PHYSICIAN'S NAME (Type) Dr. Vincent J. Fiocco		22e. ADDRESS 8 Anchor Street, Westminster, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/14/1968		23c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery				23d. LOCATION (City or Town) (County) (State) Unionville, Frederick, Md.									
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.				25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician only, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14230					14239				
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH				
First Middle Last WALTER (NMN) FIELDER					Month Day Year OCTOBER 11, 1968				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		2b. HOUR	
Male		Negro		4-19-1916		32 YRS.		3:10 PM	
7a. BIRTHPLACE (State or foreign (country))		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/>		9. COUNTY OF DEATH			
South Carolina		U.S.A.				Carroll		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Sykesville		Springfield State Hospital		Construction Worker					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Baltimore City		Baltimore				1119 Pennsylvania Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Walter Fielder			Lilly Copeland						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		246-05-3458		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinoma of the right bronchus.									
DUE TO, OR AS A CONSEQUENCE OF (b) Acute pulmonary tuberculosis.									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
1621									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 6-26-68, 19__, to 10-11-68, 19__, that (I) (we) last saw the deceased alive on 10-11-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
Agustin del Campo MD		10-11-68							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
Agustin del Campo, M. D.		Springfield State Hospital Sykesville, Maryland 21784							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-15-68		Mt. Calvary		Arlington, Md.			
24. FUNERAL DIRECTOR		ADDRESS		DATE					
Arlington S. Kelley - 2712 A. M. Ave.				OCT 14 1968					

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OFFICE OF DEATH

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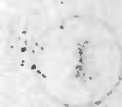
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (11-64)  
30M REV. 1-64

MEDICAL CERTIFICATION

1. DECEASED-NAME (Type or print) <b>ELIZA EMMA FLATER</b>			2a. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>9:30</b> M					
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>MARCH 24, 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GEN. HOSP. HOUSE - WIFE</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE - WIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>FINKSBURG</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RD #1</b>			
14. FATHER'S NAME First Middle Last <b>GEORGE WASHINGTON ARNOLD</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA POOLE</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service) <b>-</b>			16b. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT Address <b>JOHN W. FLATER, FINKSBURG RD #1 MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>4339</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>332x Uremia</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 25, 1968</b> , to <b>Oct 9, 1968</b> , that (I) (we) lost the deceased alive on <b>Oct 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John S. Harsney, MD</b> DEGREE 22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSNEY, MD.</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct 9, 1968</b>			
22e. ADDRESS <b>8 Archer St. Westminster, Md.</b>											
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>10/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PLEASANT GROVE CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>FINKSBURG CARROLL MD.</b>					
24. FUNERAL DIRECTOR <b>J. J. Myers Jr., Westminster, Md.</b> ADDRESS						25a. REC'D BY REGISTRAR DATE <b>OCT 14 1968</b>		25b. REGISTERED DEATH NO.			



Signature: [illegible]  
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14232

## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>George Stewart Folckemmer</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>2:10 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 1, 1909</b>		6. AGE (In years last birthday) <b>59</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>	
10. CITY OR TOWN OF DEATH <b>Sykesville, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Clerk - Civil Service</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>STATE Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1136 Falls Hill Drive</b>							
14. FATHER'S NAME <b>Chas. Warner</b>			15. MOTHER'S MAIDEN NAME <b>Bertie Fullwood</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>1942-1945</b>		17. INFORMANT <b>Springfield State Hospital, Sykesville, Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia.</b> <b>513 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>521 X</b> (b) <b>Multiple lung abscesses.</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>months</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CBS assoc. with diseases of unknown or uncertain cause.</b> <b>CBS assoc. with convulsive disorder with psychotic reaction.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/24/64</b> , 19____, to <b>10/5/68</b> , 19____, that <b>(I)</b> (we) lost the deceased alive on <b>10/5/68</b> , 19____, and that in <b>(our)</b> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Jose S. Chapulle</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/6/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Jose S. Chapulle, M.D.</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/9/68.</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evangelical Luth. Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Shrewsbury, Pa.</b>	
24. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. Balto. Md. 2 1214</b>				25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14233

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14242

1. DECEASED-NAME (Type or print) <b>WILLIAM F. GENS</b>			2a. DATE OF DEATH Month <b>OCTOBER</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>10:20</b> P	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>?-?-1877</b>		6. AGE (In years last birthday) <b>91</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Engraver</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>4619 E. Frankford Ave.</b>							
14. FATHER'S NAME First Middle Last <b>Charles Gens</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Amelia Shaefer</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		16b. SOCIAL SECURITY NO. <b>213-58-4952</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>							Years
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Arteriosclerotic Heart Disease</b>							Years
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized Arteriosclerosis</b>							Years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200 Schizophrenic Reaction.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>1-2-08</b> , 19____, to <b>10-12-68</b> , 19____, that (I) (we) lost the deceased alive on <b>10-12-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Gracito Y. Patricio</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-12-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>GRACITO Y. PATRICIO</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Freedom Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sykesville Md.</b>	
24. FUNERAL DIRECTOR <b>Harry W. Knight</b>		ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 25 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 5 Film 406 10/29/68 12

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14234

CERTIFICATE OF DEATH

14243

1. DECEASED-NAME (Type or print) <i>Florida T3 GRAY</i>			2a. DATE OF DEATH Month <i>October</i> Day <i>18</i> Year <i>1968</i>			2b. HOUR <i>6:35</i> M					
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Nov 28, 1875</i>		6. AGE (In years lost birthday) <i>92</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (State or foreign country) <i>Indiana</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>					
10. CITY OR TOWN OF DEATH <i>Marion</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Long View Nursing Home</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>Baltimore</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>1504 Kingway Rd</i>			
14. FATHER'S NAME First <i>George</i> Middle <i>H.</i> Last <i>Overleege</i>			15. MOTHER'S MAIDEN NAME First <i>Viola</i> Middle <i>Miller</i> Last <i>Miller</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i>		16b. SOCIAL SECURITY NO. <i>487-20-8895</i>		17. INFORMANT <i>Mrs Charles C Ayers</i>		Address <i>1504 Kingway Rd Baltimore Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic myocarditis</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Chronic obstructive Pulmonary Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4221</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 20</i> , 19 <i>68</i> , to <i>Oct 18</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>October 18</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Joseph E. Bush</i>		DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>Oct 18, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Joseph E. Bush</i>		22e. ADDRESS <i>Hampstead Maryland</i>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		23b. DATE <i>Oct. 19, '68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Greenmount Crematory</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore Md.</i>					
24. FUNERAL DIRECTOR <i>John E. Goff</i>		ADDRESS <i>Hampstead Md.</i>		25a. REC'D BY REGISTRAR <i>John E. Goff</i>		25b. REGISTRAR'S SIGNATURE <i>John E. Goff</i>		DATE <i>OCT 21 1968</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="display: flex; justify-content: space-between;"> <span>14235</span> <span>CERTIFICATE OF DEATH</span> <span>14244</span> </div>									
1. DECEASED-NAME (Type or print) First Middle Last <b>MARY ETTA GROFT</b>						2a. DATE OF DEATH Month Day Year <b>OCT. 8 1968</b>		2b. HOUR A.M. <b>11:45</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 7, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>6 WIMBERT AVE</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSE-WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>449 E. GREEN ST.</b>	
14. FATHER'S NAME First Middle Last <b>JOHN LITTLE</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>S. REBECCA TAWNEY</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>213-01-9164</b>		17. INFORMANT Address <b>STERLING L. GROFT, 447 E. GREEN ST. WESTMINSTER, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Stenohardness</b> DUE TO, OR AS A CONSEQUENCE OF <b>Stenohardness</b> (c) <b>Stenohardness</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5-7 yrs</b> <b>5-6 yrs</b> <b>1-2 wks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>334X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/12/63</b> , to <b>10/8/68</b> , that (I) (we) last saw the deceased alive on <b>10/7/68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>W. Glen Speicher</b>						22c. DATE SIGNED <b>10-9-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>W. GLEN SPEICHER</b>						22e. ADDRESS <b>Westminster, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>OCT. 11 '68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTMINSTER CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER MD</b>			
24. FUNERAL DIRECTOR <b>J. S. Myers Jr., Westminster, Md.</b>						25a. REC'D BY REGISTRAR <b>J. S. Myers Jr.</b>		25b. DATE <b>OCT 14 1968</b>	

14344

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14344



*Handwritten signature or initials*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile in carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14236

CERTIFICATE OF DEATH

14245

1. DECEASED-NAME (Type or print) <i>Ellie</i>		Middle <i>B.</i>		Last <i>Hammond</i>		2a. DATE OF DEATH Month <i>10</i> Day <i>31</i> Year <i>68</i>			2b. HOUR <i>9:50</i> M		
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 6, 1869</i>		6. AGE (In years last birthday) <i>99</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>					
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Gen. Hospt.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Glyndon</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>200 Waugh Ave.</i>			
14. FATHER'S NAME First <i>George</i> Middle <i>Biehl</i> Last <i>Miller</i>		15. MOTHER'S MAIDEN NAME First <i>Pnelope</i> Middle <i>Miller</i> Last <i>Miller</i>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, not (unknown) <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>219-54-0761</i>		17. INFORMANT Address <i>Mr. M. Earle Hammond Hagerstown, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>HEART FAILURE</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4200</i> (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i> <i>YEARS</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>ANEMIA, SEVERE, ETIOLOGY UNKNOWN</i>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>10/21, 1968</i> , to <i>10/21, 1968</i> , that (I) (we) last saw the deceased alive on <i>10/21, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Theresa J. Brown J. M.D.</i>				22c. DATE SIGNED <i>10/21/68</i>				22d. PHYSICIAN'S NAME (Type) <i>Theresa J. Brown J. M.D.</i>			
23a. BURIAL, CREMATION, REINTERMENT (Specify)		23b. DATE <i>Oct. 24, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Md.</i>					
24. FUNERAL DIRECTOR <i>J. F. Eline &amp; Sons Reisterstown, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>OCT 24 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14237												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14246			
1. DECEASED-NAME (Type or print) First Middle Last Charles L. Heflin												2a. DATE OF DEATH Month Day Year 10 11 68								2b. HOUR 6 35 PM							
3. SEX Male				4. RACE White				5. DATE OF BIRTH Sept. 18, 1896				6. AGE (In years lost birthday) 72 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) Virginia				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll Co., Md.															
10. CITY OR TOWN OF DEATH Westminster				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Steel Worker				12b. KIND OF BUSINESS OR INDUSTRY Balmer Corp.															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Baltimore				13c. CITY OR TOWN Glyndon				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER 11 Chatsworth Ave.											
14. FATHER'S NAME First Middle Last William Thomas Heflin				15. MOTHER'S MAIDEN NAME First Middle Last Mary T. Bayne																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No				16b. SOCIAL SECURITY NO. 214-03-7444				17. INFORMANT Address 11 Chatsworth Ave., Glyndon, Maryland Carrie Heflin																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X ACUTE PULMONARY INSUFFICIENCY 2 DAYS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC OBSTRUCTIVE PULMONARY DISEASE YEARS DUE TO, OR AS A CONSEQUENCE OF (c) (PULMONARY EMPHYSEMA)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 5271																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 10/11, 1968, to , 19 , that (I) (we) lost the deceased alive on 10/11/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE Vincent J. Fiocco, Jr. MD DEGREE												ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/11/68											
22d. PHYSICIAN'S NAME (Type) Vincent J. Fiocco, Jr.												22e. ADDRESS Westminster, Maryland.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Oct. 14, 1968				23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.				23d. LOCATION (City or Town) (County) (State) Pikesville, Balto. Md.															
24. FUNERAL DIRECTOR H. J. Ehrhardt												ADDRESS Owings Mills, Md.				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE Charles Judge							
DATE OCT 14 1968																											



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14238

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14247

1. DECEASED-NAME (Type or Print) <b>ALBERT Harrison HEISTON</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>12:00 Noon</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>12-27-07</b>	6. AGE (In years last birthday) <b>60 YRS</b>	IF UNDER 1 YEAR MONTHS <b>0</b>	IF UNDER 24 HRS. DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	IF UNDER 24 HRS. MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>25</b> Year <b>1968</b>	2d. HOUR <b>12:00 Noon</b>
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Dispatcher</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wash. Co.</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>32 Belview Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Elvy Heiston</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Lilly Smith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>214-16-1040</b>		17. INFORMANT ADDRESS <b>Springfield State Hosp. Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4201</b> (b) <b>Arterio Sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>YEARS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS assoc. with central nervous system syphilis with psychotic reaction.</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>10-25-68</b>	
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M.D.</b>				ADDRESS (Street, City or Town, County) <b>135 E. Main St. Westminster, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 29, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>			23d. LOCATION (City or Town) (County) <b>Hagerstown Washington Ind.</b>		
24. FUNERAL DIRECTOR <b>Rest Haven Funeral Chapel, Inc.</b>				ADDRESS <b>1601 Penna. Ave. Hagerstown, Ind.</b>		25a. REC'D BY REGISTRAR <b>OCT 29 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14239		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14248	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR
JOHN ERNEST HELWIG					Oct. Month 28 Day 1968		6:30 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
MALE		WHITE		JUNE 25, 1883		85 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
MARYLAND		U. S. A.				CARROLL Co.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER		CARROLL Co. Gen. Hosp.		FARMER AND MECHANIC			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
MARYLAND		CARROLL		WESTMINSTER		57 WEBSTER ST. 1	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
HENRY				HELWIG	LOUISA CATHERINE UTERMÄHLEN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO				213-18-9481-A		MRS R.N. FOWLER, 57 WEBSTER ST. WESTMINSTER MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) _____							
519.2 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) Chronic obstructive Pulmonary Disease							
DUE TO, OR AS A CONSEQUENCE OF							
(c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
5272							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Dec, 1967, to Oct 28, 1968, that (I) (we) last saw the deceased alive on Oct 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
John S. Harshey, MD						10/28/68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS					
JOHN S. HARSHEY MD		8 Archer St Westminster, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		10/31/68		PLEASANT VALLEY CEM		PLEASANT VALLEY, CARROLL MD.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. E. Miller, Jr., Westminster, Md.				NOV 1 1968		J. Charles Judge	

84321

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315

100-100000



NOV 1 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14240

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14249

1. DECEASED-NAME (Type or print) <i>Cona</i>		First	Middle	Last	2a. DATE OF DEATH Month <i>10</i> Day <i>23</i> Year <i>68</i>			2b. HOUR <i>7:54</i> AM	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>April 26, 1899</i>		6. AGE (In years last birthday) <i>69</i>		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Washington Co.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Carroll</i>			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Carroll Co. Gen. Hospt.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Cockeysmill Rd.</i>	
14. FATHER'S NAME <i>John</i>		First	Middle	Last	15. MOTHER'S MAIDEN NAME <i>Alice</i>		First	Middle	Last <i>Smith</i>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown		16b. SOCIAL SECURITY NO. <i>213-20-4895</i>		17. INFORMANT <i>Mr. Warner T. Higgs</i>		Address <i>Reisterstown, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL ANOXIA</i> <i>4129</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 DAYS</i> <i>MONTHS</i> <i>YEARS</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4200</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>10/12, 1968</i> , to <i>10/23, 1968</i> , that (I) (we) last saw the deceased alive on <i>10/23, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Vincent J. Krasin Jr. MD</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>10/23/68</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Oct. 26, 68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Good Shephard</i>		23d. LOCATION (City or Town) (County) (State) <i>Ellicott City, Md.</i>			
24. FUNERAL DIRECTOR <i>J. F. Cline &amp; Sons</i>				ADDRESS <i>Reisterstown, Md.</i>		25a. REC'D BY REGISTRAR <i>Oct 25 1968</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Judge</i>	

14249

RECEIVED DE DEATH

14249



14249

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14241

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14250

1. DECEASED-NAME (Type or print) <b>George Edward Hilton</b>			2a. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>8:45A</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>9-23-1887</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired Machinist</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Allegheny</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Route #6 Cumberland, Md.</b>	
14. FATHER'S NAME First Middle Last <b>Warren Eugene Hilton</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida C. Uhl</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>705-05-4548</b>		17. INFORMANT Address <b>Hospital Records</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4379</b> (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF <b>334x</b> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Psychosis with cerebral arteriosclerosis, paranoid type</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>1-9-</b> , <b>1950</b> , to <b>10-12</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>10-12-</b> , <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Suha Ozgun</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-12-1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Suha Ozgun</b>				22e. ADDRESS <b>Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/15/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Eckhart, Alleg Md.</b>			
24. FUNERAL DIRECTOR <b>Charles E. Hafer</b>				ADDRESS <b>230 Balto Ave., Cumberland Md</b>		25a. RECD BY REGISTRAR <b>OCT 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

14820

14820

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14242

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14251

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR	
ELWOOD CHARLES		HOBBS.						10-31		1968						P M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		Month		Day		Year	
Male	White	June 13, 1914		54 YRS.		MONTHS		DAYS		10		31		1968		P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH									
Maryland		U.S.A.		WIDOWED		DIVORCED		Carroll									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY											
Keysville				Truck Driver		Hauling											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Maryland		Carroll		Keysville		YES X NO											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last			
Unknown								Florence						Hyde			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		WW2		213-18-9590		Mrs. Agnes Hobbs, Keymar R #1, Maryland											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CORONARY THROMBOSIS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		10-11 hrs							
4109				DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)		DUE TO, OR AS A CONSEQUENCE OF											
				(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		4201															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO X									
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State							
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from:		Natural causes X		Accident		Suicide		Homicide		Undetermined manner	
ACTUAL SIGNATURE		W. Glenn Speicher		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		10-31-68					
EXAMINER'S NAME (Type)		W. Glenn Speicher		135 E. Main St. Westminister, Carroll													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)							
Burial		11/3/68		Kriders Cemetery		Westminister, Carroll, Maryland											
24. FUNERAL DIRECTOR		C.O. Fuss & Son		ADDRESS		Taneytown, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		NOV 4 1968		J. Charles Judge			

14821

NOV 4 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film 406 10/29/68 KK									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14242									
14252									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last					2a. DATE OF DEATH Month Day Year			2b. HOUR	
William T. Johnson					10 23 68			4 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
male		white		12/11/92		75 7/4 YRS.		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Johnson Co. N.C.		USA.				Carroll.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Manchester, Md.		Ingrown Nailing Home		Hosp. attendant					
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
md		Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD #4 Sykesville, Md.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Johnson			Corrine Stevenson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT (son)		Address			
no		240-22-2814		Wm. Johnson		909 Lando Rd. Sykesville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129									
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Myocarditis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Cerebrovascular Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4221									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1968, to 10-23, 1968, that (I) (we) last saw the deceased alive on 10-23, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Joseph E. Bush MD		10-23-68		Joseph E. Bush MD		Hampstead Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-26-68		Mt. View Cemetery		Howard Co. Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry Wren Haight		Sykesville, Md.		DATE OCT 25 1968		J. Charles Judge			

1932

RECEIVED

1932

1

1932

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>FRANK HENRY JONES</b>						2a. DATE OF DEATH Month Day Year <b>OCTOBER 25, 1968</b>			2b. HOUR A M <b>8:30 M</b>		
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>10-27-1897</b>		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>2800 Presstman St.</b>			
14. FATHER'S NAME First Middle Last <b>Frank Jones</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Janie Weathers</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>Unk.</b>		16b. SOCIAL SECURITY NO. <b>216-01-0036-4</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery sclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic fibrous pulmonary tuberculosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>5-1-63</b> , 19____, to <b>10-25-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-25-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Jose Chapulle</b>						DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-25-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Jose Chapulle, M. D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/28/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Anne Arundel Cty. Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. C. March</b>				ADDRESS <b>928 E. North Ave</b>		25a. REC'D BY REGISTRAR <b>OCT 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

14323

14323

14323



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14245

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14254

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED		Month		Day		Year		2b. HOUR		M	
HOWARD ETHELBERT		KELLER						10-17		1968						7		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		HOURS		MIN.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Male		White		Dec. 26, 1877		90 YRS.										Month 10 Day 28 Year 1968		1138 M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH											
Md.		USA		WIDOWED		DIVORCED		Carroll										Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
Sykesville		Arthur Ave.		Farmer															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Md.		Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Arthur Ave.											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
Peter E. Keller								Katherine Davis											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		215-24-7576		Mrs. Shirley Horton		Sykesville, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4129		Arterio Sclerotic Heart Disease				years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
				(c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		4200																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State									
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion											
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		W. E. Speicher		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED		10-27-68					
EXAMINER'S NAME (Type)						ADDRESS (Street, P.O. Box, or Rural Route)													
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)											
Burial		Oct. 30, 1968		Evergreen Memorial Gardens		Finksburg, Md.													
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Tipton - Eline Funeral Home		Hampstead, Md.		OCT 31 1968		Charles Judge													

14324

14324

Carroll

USA

NO.

Carroll

Carroll

Carroll

Carroll

Carroll

Carroll

Carroll

Carroll

14324

14324

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14246										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14255																													
1. DECEASED-NAME (Type or print)										20. DATE OF DEATH										2b. HOUR																													
First Middle Last JOHN MICHAEL KNATZ										Month Day Year 10 25 68										3 35 M																													
3. SEX MALE										4. RACE WHITE										5. DATE OF BIRTH JAN. 1, 1896										6. AGE (In years lost birthday) 72 YRS.										IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.									
7a. BIRTHPLACE (State or foreign country) MARYLAND										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH CARROLL CO. Md.																			
10. CITY OR TOWN OF DEATH WESTMINSTER										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL CO. GENERAL										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) farmer										12b. KIND OF BUSINESS OR INDUSTRY U.S.A.																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.										13b. COUNTY CARROLL CO.										13c. CITY OR TOWN WESTMINSTER										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER R.F.D. 2									
14. FATHER'S NAME First Middle Last EDWARD G. Knatz										15. MOTHER'S MAIDEN NAME First Middle Last SARAH REBECCA HOFFMAN										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) NO										16b. SOCIAL SECURITY NO. NONE										17. INFORMANT Address Mr. Philip Knatz, Emory Rd., Upperville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 ACUTE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YEARS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS																																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																																																	
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																													
22a. I certify that (I) (this hospital) attended the deceased from 10/22, 1968, to 10/25, 1968, that (I) (we) last saw the deceased alive on 10/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																	
22b. SIGNATURE Vincent J. Frosco J. MD										22c. DATE SIGNED 10/25/68										22d. PHYSICIAN'S NAME (Type) 22e. ADDRESS																													
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE Oct. 28, 1968										23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial										23d. LOCATION (City or Town) (County) (State) Finksburg, Carroll Co. Md.																			
24. FUNERAL DIRECTOR Frank H. Newell, Pikesville, Md.										25a. REC'D BY REGISTRAR NOV 4 1968										25b. REGISTRAR'S SIGNATURE Charles Judge																													

1101

14325

(1961-12-01)

NOV 22 1961

1961

1961

RECEIVED  
GENERAL INVESTIGATION  
UNITED STATES DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

DATE: 11/22/61  
BY: [illegible]  
11/22/61

NOV 1 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14247

14256

1. DECEASED-NAME (Type or print) <b>Bertha Mae Lentzner</b>			2a. DATE OF DEATH Month <b>Oct</b> Day <b>20</b> Year <b>68</b>			2b. HOUR <b>7:34</b> M					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7/29/1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Manchester, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Longview Nursing Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>RFD 6</b>			
14. FATHER'S NAME First <b>Stoner</b> Middle <b>Lepp</b> Last <b>Lepp</b>		15. MOTHER'S MAIDEN NAME First <b>ANNIE</b> Middle <b>GORE</b> Last <b>GORE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO. <b>213-38-7807100</b>		17. INFORMANT <b>Wm Lentzner</b>		Address <b>Westminster, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>3 yrs</b> <b>5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4200</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/13</b> , 19 <b>68</b> , to <b>10/20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>10/19</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>W H Foward</b>		M.D. DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/20/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>W H Foward M.D.</b>		22e. ADDRESS <b>Manchester, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hammer Carroll Co. Md.</b>					
24. FUNERAL DIRECTOR <b>J. S. Myers Jr.</b>				ADDRESS <b>Westminster, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 22 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>			

14328

REPUBLIC OF CHINA

14328

REPUBLIC OF CHINA

REPUBLIC OF CHINA



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14248		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14257	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year	
Jacob (NMN) Levine						October 31, 1968	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	
Male		White		1-27-1894		74 YRS.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Maryland		U.S.A.				Carroll County, Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville		Springfield State Hospital		Clothing cutter (retired)			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland Balto. City			Baltimore				6946 Millbrook Drive
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME				
First Middle Last			First Middle Last				
Hyman Levine			Belle			? /	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address	
None NO		212-03-3380A		MRS. DOLLY LEVINE		6946 MILLBROOK DR., APT. T-1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART 1. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)							
Chronic brain syndrome associated with cerebral arteriosclerosis without qualifying phrase (Diabetes Mellitus)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 9-13-68, 19__, to 10-31-68 19__, that (I) (we) last saw the deceased alive on 10-31-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
Paul G. Ensor, M.D.				Springfield State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
BURIAL		11-1-68		BETH ISAAC ADATH ISRAEL		BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD				DATE NOV 4 1968		f Charles Judge	

14257

DEPARTMENT OF DEATH

14257



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11-1-63

11-1-63

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-11-68  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Frank Ivan Lewis</b>						2a. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>8:00 PM</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-21-08</b>		6. AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County</b> Md.					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Lantz</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Route 1</b>			
14. FATHER'S NAME First Middle Last <b>David Lewis</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Clare Toms</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>none</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>220-54-2866</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <b>Acute pulmonary edema, due to</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <b>Hypertensive cardiovascular disease</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
<b>443X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>9-27-68</b> to <b>10-3-68</b> , that (I) (we) last saw the deceased alive on <b>10-3-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Octavio A. Ruiz, M.D.</b>						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-4-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>						22e. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>10-7-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Methodist Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Foxville Fred. Col Md.</b>			
24. FUNERAL DIRECTOR <b>Raymond E. Greager</b>						ADDRESS <b>Thurmont, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Journal of Management Education 35(10) 1103-1116

	Female	Male
Age	22.2	22.2
Height	162.5	175.5
Weight	55.5	75.5
Body mass index	20.8	24.5
Heart rate	145	145
Stroke volume	100	100
Cardiac output	14.5	14.5
Stroke work	1.0	1.0
Stroke power	1.0	1.0
Stroke volume index	62.5	57.5
Cardiac output index	90.0	82.5
Stroke work index	6.2	5.7
Stroke power index	6.2	5.7

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14250

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14259

1. DECEASED-NAME (Type or print) <b>Aurelia Christine Likins</b>			2a. DATE OF DEATH <b>10</b> Month <b>18</b> Day <b>68</b> Year			2b. HOUR <b>am</b> <b>10:00</b>				
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>1/16/90</b>		6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>3205 Rolling Road</b>	
14. FATHER'S NAME First <b>George</b> Middle <b>-</b> Last <b>Kruse</b>			15. MOTHER'S MAIDEN NAME First <b>Amelia</b> Middle <b>-</b> Last <b>?</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>486-10-4040D</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia.</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4300</b> (b) <b>Arteriosclerotic heart disease.</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>yrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis with behavioral reaction.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>2/19/</b> , 19 <b>67</b> , to <b>10/18/</b> , 19 <b>68</b> , that <del>he</del> (we) last saw the deceased alive on <b>10/18/</b> , 19 <b>68</b> , and that in <del>our</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>did not</del> view the body after death.										
22b. SIGNATURE <b>Renato R. Espina, M.D.</b> DEGREE <b>MD</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>10/18/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Renato R. Espina, M. D.</b>						22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>10-22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge.</b>		

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "P-13" 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14251

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14260

1. DECEASED-NAME (Type or Print) <b>ANNIE MAY LITCHFIELD</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR <b>6:58</b> M <b>M</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>MAY 15, 1884</b>	6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>17</b> Year <b>1968</b>
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Carroll</b>			Md.
10. CITY OR TOWN OF DEATH <b>Sykesville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Klee Mill Road</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>CARROLL</b>	13c. CITY OR TOWN <b>Sykesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Klee Mill Road</b>		
14. FATHER'S NAME First <b>Henry</b> Middle <b>B.</b> Last <b>Streib</b>	15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>E.</b> Last <b>Hefferman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16b. SOCIAL SECURITY NO. <b>215 01 0400 B</b>	17. INFORMANT <b>MR. HARRY Litchfield</b> ADDRESS <b>Sykesville, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Breast &amp; metastases 9 yrs</b> <b>174X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>&amp; cachexia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>170X</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION <b>170X</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>						
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10-17-68</b>			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher</b>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>10-21-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lake View Cemetery</b>	23d. LOCATION (City or Town) <b>Sykesville, Md.</b>	(County) <b>Carroll</b>		
24. FUNERAL DIRECTOR <b>Harry W. Knight</b>	ADDRESS <b>Sykesville, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 22 1968</b>	25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14252												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14261			
1. DECEASED-NAME (Type or print) <b>MARY</b> <b>JANE</b> <b>MAHOLM</b>												2a. DATE OF DEATH Month <b>10</b> Day <b>25</b> Year <b>68</b>												2b. HOUR <b>9:25am</b>			
3. SEX <b>Female</b>				4. RACE <b>Caucasion</b>				5. DATE OF BIRTH <b>03-12-09</b>				6. AGE (In years last birthday) <b>59</b> YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Carroll County</b> Md.															
10. CITY OR TOWN OF DEATH <b>Sykesville, Maryland</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield St. Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>none</b>															
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> 13b. COUNTY <b>Washington</b>				13c. CITY OR TOWN <b>Hagerstown</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER <b>1234 W. Washington St.</b>															
14. FATHER'S NAME First <b>OLIVER</b> Middle <b>W</b> Last <b>C. SMALL SR.</b>												15. MOTHER'S MAIDEN NAME First <b>Edna</b> Middle <b>Unknown</b> Last <b>B. HOCKERSMITH</b>															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>577-01-2683</b>				17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4201</b> (b) <b>Coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Brain Syndrome associated with presenile brain disease with behavioral reaction.</b>																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>  <b>Years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic Brain Syndrome associated with presenile brain disease with behavioral reaction.</b>																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/27</b> , 19 <b>68</b> , to <b>10/25</b> , 1968, that <b>(X)</b> (we) last saw the deceased alive on <b>10/25</b> , 1968, and that in <b>(X)</b> (our) opinion death occurred on the date and hour and from the causes stated above, <b>(X)</b> (we) (did) <b>(did not)</b> view the body after death.																											
22b. SIGNATURE <b>Naci Buyukunsal, M.D.</b>												DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>10/25/68</b>											
22d. PHYSICIAN'S NAME (Type) <b>Naci Buyukunsal, M.D.</b>												22e. ADDRESS <b>Springfield State Hospital</b> <b>Sykesville, Maryland</b>															
23a. BURIAL, CREMATION, or REMOVAL (Specify) <b>BURIAL</b>				23b. DATE <b>10/28/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>				23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH, MD</b>															
24. FUNERAL DIRECTOR <b>W.T. Noorment</b>												ADDRESS <b>RT 5 NAC. MD</b>				25a. REC'D BY REGISTRAR <b>OCT 30 1968</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last <b>Theresa E. Marx</b>						2a. DATE OF DEATH Month Day Year <b>Oct 30 1968</b>		2b. HOUR M <b>11</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>10-25-1875</b>		6. AGE (In years last birthday) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.			
10. CITY OR TOWN OF DEATH <b>Holbrook</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chapel Hill N.H.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>AT Home</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore</b>		13c. CITY OR TOWN <b>Balto</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>3619 Langrehr Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Kirsch</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Elsa Keith-7926 Dunhill Village Circle</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>4120</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia - bronchial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis Cardio Vascular Disease</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 week</b> <b>13 Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) <b>443X</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 16, 1968</b> , to <b>Oct 30, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Edwin L. Pierpont, M.D.</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>10/11/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>EDWIN L. PIERPONT, M.D.</b>				22e. ADDRESS <b>8204 LIBERTY RD - BALTO 21207 MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11-2-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR ADDRESS <b>Ellsworth Armacost -4600 Liberty Hghts. Ave</b>				25a. RECEIVED BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Item 18 Film 407 11-29-68 <b>MARYLAND STATE DEPARTMENT OF HEALTH</b> DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
<b>14254</b> <b>CERTIFICATE OF DEATH</b> <b>14263</b>											
1. DECEASED-NAME (Type or print) <b>Elmer Elsworth Maurer</b>						2a. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1968</b>			2b. HOUR <b>9:35</b> MIN <b>A</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>4-14-22</b>		6. AGE (In years last birthday) <b>46</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll County, Md.</b>					
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>None</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Baltimore City</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>105 N. Rose Street</b>			
14. FATHER'S NAME First <b>William Frederick</b> Middle <b>Maurer</b>				15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Mandley</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records, Springfield State Hospital, Sykesville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhagic pneumonia, bilateral</b> <b>486 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Septicemia, organism to be determined</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Days</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>493 X</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? Partial YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>11-30-59</b> , 19____, to <b>10-30-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-30-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Octavio A. Ruiz, M.D.</b>						DEGREE <b>M.D.</b> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10-30-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M.D.</b>						22e. ADDRESS <b>Sykesville, Maryland Springfield State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>11/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>					
24. FUNERAL DIRECTOR <b>John A. Moran, Inc. 3000 E. Baltimore St.</b>						25a. REC'D BY REGISTRAR <b>NOV 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14303

RECORD OF DEATH

14303

Nov 1 1968

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14255										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										14264									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1. DECEASED-NAME (Type or Print) <b>CHARLES KENNETH MEEM</b>										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>17</b> Year <b>1968</b>										2b. HOUR <b>4:55</b> AM <input type="checkbox"/> PM									
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7-20-1895</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>17</b> Year <b>1968</b>										2d. HOUR <b>4:55</b> AM <input type="checkbox"/> PM							
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH <b>Carroll</b>										Md.							
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>								12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Food Brokerage</b>				12b. KIND OF BUSINESS OR INDUSTRY													
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Montgomery</b>										13b. CITY OR TOWN <b>Bethesda</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>6100 Cheshire Dr.</b>															
14. FATHER'S NAME First <b>Otto</b> Middle <b>C.</b> Last <b>Meem</b>					15. MOTHER'S MAIDEN NAME First <b>Ella</b> Middle <b></b> Last <b>Beall</b>																								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>					16b. SOCIAL SECURITY NO. <b>579-40-9942A</b>					17. INFORMANT ADDRESS <b>Records, Springfield State Hospital</b>																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriolar nephrosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4120</b> <b>4200</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>CBS with other diseases of unknown or uncertain cause, with psychotic reaction. Presenile psychosis. Fracture, left hip.</b>																													
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>					21b. TIME OF INJURY Month, Day, Year <b>10-12-68</b> HOUR A.M. <b>4:25</b>					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) <b>Fell out of bed.</b>																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>T.B. 1, Springfield State Hospital, Sykesville, Carroll, Maryland</b>					21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																													
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					22b. DATE SIGNED <b>10-17-68</b>																			
EXAMINER'S NAME (Type) <b>W. Glenn Speicher, M. D.</b>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					1356 Union St. Westminster Carroll																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>					23b. DATE <b>10-21-1968</b>					23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEM</b>																			
23d. LOCATION (City or Town) <b>ROCKVILLE, MARYLAND</b>					23e. COUNTY <b>Carroll</b>					23f. STATE <b>Md.</b>																			
24. FUNERAL DIRECTOR <b>W. W. Chambers 1400 Chapin Washington D.C.</b>					25. REC'D BY REGISTRAR <b>OCT 23 1968</b>					25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>																			

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## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) Lucille Mae Miller			2a. DATE OF DEATH Month Day Year October 15, 1968			2b. HOUR :7:20PM				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 7-3-92		6. AGE (In years last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.				
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Springfield State Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home keeping				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 916 E. Belvedere Ave.	
14. FATHER'S NAME First Middle Last Henry Crider			15. MOTHER'S MAIDEN NAME First Middle Last Obie Carl							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 215- 34-7126		17. INFORMANT Address Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Bronchopneumonia 4129 DUE TO, OR AS A CONSEQUENCE OF Congestive Heart Failure (b) Arteriosclerotic Heart Disease (c) years. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days weeks years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 Chronic Brain Syndrome										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 11-15-66, 19____, to 10-15-68, 19____, that (I) (we) last saw the deceased alive on 10-15-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Gracito V. Patricia M.D. DEGREE PHYS. MED. DIRECTOR STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED 10-15-68					
22d. PHYSICIAN'S NAME (Type) GRACITO V. PATRICIO					22e. ADDRESS S. S. H.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/15/68		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION (City or Town) (County) (State) Baltimore MD.				
24. FUNERAL DIRECTOR Lassahn Funeral Home		ADDRESS 7401 Belair Rd.		25a. REC'D BY REGISTRAR DATE OCT 21 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				

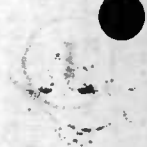
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14222

UNITED STATES OF AMERICA

14222



14222



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
GEORGE			(NMN)			MORRISON		OCTOBER 17, 1968 7 <sup>25</sup> M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		Unknown		71? YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.				Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Unk.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER No fixed address prior to admission to hospital	
Maryland			Baltimore City		Baltimore					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Unk.			Bertha			Unk.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (na, or unknown) Yes?			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
1917-18?			220-54-7132		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 403 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephrosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Bronchopneumonia. Mental deficiency (familial or hereditary), severe. 446 X								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 1-5-37, 19__, to 10-17-68, 19__, that (I) (we) last saw the deceased alive on 10-17-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Paul G. Ensor, M.D.					22c. DATE SIGNED 17 OCT 68					
22d. PHYSICIAN'S NAME (Type) Paul G. Ensor, M. D.					22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784					
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town) (County) (State)				
Burial		10-24-68		New Cathedral Cemetery		Baltimore, Md.				
24. FUNERAL DIRECTOR Larry W. Haight Sykesville, Md.					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge			
					DATE OCT 25 1968					

BUREAU OF PLANT INDUSTRY

WASHINGTON, D. C.

1918

Cotton

U. S. A.

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

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No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

Cotton, Ginned, 100 lbs. per bale

No. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15  
30M REV.

14253

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14267

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
GRACE			Viola		TRIVERS	Month 10 Day 18 Year 68			35 M 22		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		JAN. 29, 1890		78 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md.		USA				Carroll Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll Co. Gen. Hospital			Housewife			Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Carroll		Friselburg				Westminster RD #7		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Martin			J.		Zimmesman	Emma					Albaugh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
No			?			Walter W Myers Jr.			Westminster RD #7 Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CARCINOMA OF LUNG, RIGHT,</u>											
DUE TO, OR AS A CONSEQUENCE OF											
<u>1621</u> <u>WITH METASTASES</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
<u>163 X ARTERIOSCLEROTIC HEART DISEASE</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
			HOUR A.M. Month Day Year								
			P.M. 19								
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			Street or R.F.D. No. City or Town County State		
While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
22a. I certify that (I) (this hospital) attended the deceased from <u>9/5</u> , 19 <u>68</u> , to <u>10/18</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						22c. DATE SIGNED					
<u>Walter W Myers Jr.</u>						10/18/68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			10-22-68			Bassett Cemetery			Friselburg Carroll Md		
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
<u>J. J. Myers Jr.</u>						DATE			<u>OCT 22 1968</u>		
									<u>Charles Judge</u>		

V

1984

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14255

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14268

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) <b>HARRY WILLIAM NUSBAUM</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>9</b> Year <b>1968</b>			2b. HOUR <b>2:45</b> P.M.			
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>JULY 27-1899</b>	6. AGE (In years last birthday) <b>69</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>9</b> Year <b>1968</b>			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL</b>			
10. CITY OR TOWN OF DEATH <b>TANEYTOWN RURAL</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>BAPTIST ROAD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>TANEYTOWN</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>BAPTIST ROAD</b>	
14. FATHER'S NAME First <b>DAVID</b> Middle <b></b> Last <b>NUSBAUM</b>			15. MOTHER'S MAIDEN NAME First <b>MARY</b> Middle <b>MARTIN</b> Last <b></b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>W W I</b>		(If yes give war or dates of service) <b>W W I</b>		16b. SOCIAL SECURITY NO. <b>216-146129</b>		17. INFORMANT <b>GRACE NUSBAUM</b>			
						ADDRESS <b>RURAL TANEYTOWN MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarct (acute)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>10/9/68</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. <b></b>		City or Town <b></b>		County <b></b>
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>W Glenn Speicher</b>			M.D. <b></b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>10-9-68</b>	
EXAMINER'S NAME (Type) <b>W GLENN SPEICHER</b>			ADDRESS <b>155 S. Main St. New Windsor, Md.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>OCT 12-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BAUST</b>		23d. LOCATION (City or Town) <b>TANEYTOWN</b>		(County) <b>MD</b>	
24. FUNERAL DIRECTOR <b>SA Fritzler &amp; Sons, New Windsor, Md.</b>				ADDRESS <b></b>		25a. REC'D BY REGISTRAR DATE <b>OCT 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

14368

1981 11 130



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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14260

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14269

1. DECEASED-NAME (Type or Print) <b>GEORGE WASHINGTON OWINGS</b>			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year <b>10-5-1968</b>			2b. HOUR OF DEATH M <b>5:00</b>		
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>JAN. 13, 1894</b>	6. AGE (In years last birthday) <b>74</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>5</b> Year <b>1968</b>			2d. HOUR M <b>5:20</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL Co.</b>					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER RT#4</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HOOK ROAD</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SELF.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>CARROLL WESTMINSTER</b>			13c. CITY OR TOWN <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>			13d. INSIDE CITY LIMITS? <b>HOOK ROAD</b>		
14. FATHER'S NAME First Middle Last <b>GEORGE MONROE OWINGS</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>MARTHA ELLEN CAPLE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>W.N.I. 219-36-0107</b>			17. INFORMANT ADDRESS <b>MRS. GEO. W. OWINGS, WESTMINSTER, RT#4, MD.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>4100</b> (b) <b>Hypertension &amp; A.S. C.V. disease</b> DUE TO, OR AS A CONSEQUENCE OF <b>2-3 yrs</b> With Angina (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. E. Speicher</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>10-5-68</b>			
EXAMINER'S NAME (Type) <b>W. E. Speicher</b>				ADDRESS <b>135 E. Main, Westminster, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>10/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>DEER PARK CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>SMALLWOOD CARROLL, MD.</b>			
24. FUNERAL DIRECTOR <b>J. E. Myers, Jr., Westminster, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

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east.

54-28-0103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1.5 (11-60)  
30M REV. 1-65

14261												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14270																							
1. DECEASED-NAME (Type or print) First Middle Last William F OWINGS												2a. DATE OF DEATH Month Day Year Oct 1 1968												2b. HOUR 6:30 A.M.																							
3. SEX Male				4. RACE white				5. DATE OF BIRTH July 2-1886				6. AGE (In years last birthday) 82 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.																											
7a. BIRTHPLACE (State or foreign country) Baltimore, Md				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll Md.																																			
10. CITY OR TOWN OF DEATH Manchester				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Construction Cabinet				12b. KIND OF BUSINESS OR INDUSTRY maker																																			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md				13b. COUNTY Batts.				13c. CITY OR TOWN Reisterstown				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET AND NUMBER 316 Main St. 21136.																															
14. FATHER'S NAME First Middle Last Samuel Owens				15. MOTHER'S MAIDEN NAME First Middle Last Sarah E Foudrey																																											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no.				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 216-10-3285				17. INFORMANT Address Maurice R Owens (son) 215 Concord Ave Reisterstown, Md.																																							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic cardio vascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs																																			
19a. DATE OF OPERATION 4/22/61												19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19												21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>												21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)												21f. LOCATION Street or R.F.D. No. City or Town County State																							
22a. I certify that (I) (this hospital) attended the deceased from May 25, 1968, to Oct 1, 1968, that (I) (we) last saw the deceased alive on Sept 28, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22b. SIGNATURE W H Foward M.D. DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10/1/68												22c. DATE SIGNED																							
22d. PHYSICIAN'S NAME (Type) W. H Foward M.D.												22e. ADDRESS MANCHESTER, MD 21102																																			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial												23b. DATE Oct. 4, 68												23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery												23d. LOCATION (City or Town) (County) (State) Reisterstown, Md.											
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.												25a. REC'D BY REGISTRAR DATE OCT 4 1968												25b. REGISTRAR'S SIGNATURE Charles Judge																							

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(M)

(1)

James E. Ford  
2-10-32  
310 West 30th St  
New York City

Oct 1 1938

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1515  
30M REV. 11-68

MARTLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR A M
LOUIS			(NMN)			PARKER			OCTOBER 8, 1968
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male		Negro		1-25-1898		70			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Illinois			U.S.A.				Carroll		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Sykesville			Springfield State Hospital			Laborer			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Baltimore City		Baltimore		YES		2909 N. Presstman St.
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last
Unk.						Unk.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			705-10-6276-A			Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Nephrosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>446 X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) CBS associated with cerebral arteriosclerosis, with behavioral reaction									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>1-19-68</u> , 19____, to <u>10-8-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>10-8-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Octavio A. Ruiz M.D.</u> DEGREE						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-8-68	
22d. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.						22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		10-12-68		St. Lukes Cemetery		Sykesville Md.			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>						25a. REC'D BY REGISTRAR DATE OCT 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First F.		Middle ELIZABETH		Last PICKETT		2a. DATE OF DEATH Oct. Month 23, Day 1968 Year		2b. HOUR 3P. M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 8, 1888		6. AGE (In years last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll		Md.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R. D. 3		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R. D. 3			
14. FATHER'S NAME Levi		First T.		Middle Haines		15. MOTHER'S MAIDEN NAME Amanda		First J.		Middle Jenkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 213-24-8502		17. INFORMANT Mrs. Pearl Knapp		Address Same As #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 428x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Tubercular Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4232											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 10/21/1968, to 10/23/1968, that (I) (we) last saw the deceased alive on 10/21/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Wm E. Martine M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10/23/68	
22d. PHYSICIAN'S NAME (Type) Wm E. Martine M.D.		22e. ADDRESS Winfield Carroll, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 10/26/1968		23c. NAME OF CEMETERY OR CREMATORY Ebenezer		23d. LOCATION (City or Town) Winfield		(County) Carroll		(State) Md.	
24. FUNERAL DIRECTOR C. M. Waltz, Box 241, Sykesville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE OCT 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

14515

CONFIDENTIAL

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**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1b. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14266

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

14273

1. DECEASED-NAME (Type or Print) <b>ALICE MARIE RAY</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>10</b> Day <b>31</b> Year <b>1968</b>			2b. HOUR <b>2:45</b> M <b>A</b>		
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>July 12, 1911</b>	6. AGE (In years last birthday) <b>57</b> YRS.	7. UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>1</b>	IF UNDER 24 HRS. HOURS <b>1</b> MIN. <b>15</b>	2c. DATE PRONOUNCED DEAD Month <b>10</b> Day <b>31</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>		
10. CITY OR TOWN OF DEATH <b>Hampstead</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>216 S. Main Street</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <b>Maryland</b>			13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Hampstead</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>216 S. Main Street</b>		
14. FATHER'S NAME <b>James Carlisle</b>			15. MOTHER'S MAIDEN NAME <b>Annie Berry</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Family information</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (acute)</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>W. Glenn Speicher</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>10-31-68</b>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Nov. 2, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Jessops Cemetery</b>		23d. LOCATION (City or Town) (County) <b>Rockeysville, Md.</b>	
24. FUNERAL DIRECTOR <b>John Burns' Sons, Towson, Maryland</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
CLAUDE VERNON REBERT					Month	Day	Year	12:30	P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
MALE		WHITE		MARCH 25, 1893		85 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
MARYLAND		U.S.A.				CARROLL CO.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
WESTMINSTER		175 FRANKLIN AVE.		FARMER					
13a. USUAL RESIDENCE (Where deceased admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
MD.		CARROLL		WESTMINSTER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		175 FRANKLIN AVE.	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
EMMANUEL				REBERT	CLARA				REMSBURG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		212-38-1029		NORMAN O. REBERT		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis (acute)</u> 4109 DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerotic heart</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dissecting + coronary insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>&amp; Sclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden 9-10410	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 <u>Carcinoma Bladder - 1963</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
7/26/63		Ca Bladder			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>OCT 28, 1959</u> , to <u>OCT 28, 1968</u> , that (I) (we) last saw the deceased alive on <u>OCT 28, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. Glenn Speicher MD</u>				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10-29-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS Westminster Md 21157					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		10/31/68		LEISTERS CEMETERY		WESTMINSTER		MD	
24. FUNERAL DIRECTOR <u>J. E. Meyer Jr.</u>				ADDRESS <u>Westminster, Md</u>		25. REC'D BY REGISTRAR DATE NOV 1 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



14214

U. S. DEPARTMENT OF DEATH

14214





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

14266

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14275

1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR Min.		
CLARENCE EDWARD RICHMOND						OCTOBER 31, 1968			10 <sup>00</sup> P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		White		4-24-1899		69 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		Md.			
West Virginia		U.S.A.				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Sykesville		Springfield State Hospital		Carpenter							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Howard		Ellicott City				905 Balto. National Pike			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
George					Richmond	Mary					Kiger
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
Yes		1942		232-18-3026		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 332x (b) <u>Severe generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Large decubiti.</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>8-28-68</u> , 19 <u>  </u> , to <u>10-31-68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>10-31-68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Paul G. Ensor, M.D.</u>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/31/68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Paul G. Ensor, M. D.</u>						22e. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
<u>Burial</u>		<u>11-9-68</u>		<u>Freedom</u>		<u>Sykesville</u>		<u>Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>						ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 18 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14375

CERTIFICATE OF DEATH

1938

NOV 18 1938

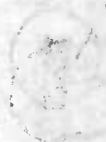
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		Johanna		Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Johanna		NMN		Rose		Month - Day - Year 10 - 16 - 68		7:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		6-3-91		77 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Germany		USA				Carroll		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Rural-Sykesville		Springfield St. Hosp.		Housewife					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Md.		Mont.		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2410 Colston Drive	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Leopold ?		Amalia ?		no		None		Springfield St. Hospital records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 486x		DUE TO, OR AS A CONSEQUENCE OF (b) 486x		DUE TO, OR AS A CONSEQUENCE OF (c) 486x		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)		Chronic Brain Syndrome, assoc. with cerebral arteriosclerosis c psy. reaction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work								County	
								State	
22a. I certify that (I) (this hospital) attended the deceased from 3-8-67, 1967, to 10-16-68, 1968, that (I) (we) last saw the deceased alive on 10-16-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Robert P. Sagisi		10-16-68		GLOCRITO SAGISI		Springfield St. Hospital		Sykesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		10/18/68		Mt. Lebanon Cemetery		Hyattsville, Md.			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Bernard Danzansky & Sons		OCT 21 1968		Charles Judge					

1937

RECEIVED



1937

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14268 CERTIFICATE OF DEATH 14277											
1. DECEASED-NAME (Type or print) First Middle Last BIRCKHEAD -- ROUSE						2a. DATE OF DEATH Month Day Year 10 - 29 - 68			2b. HOUR 12:35 PM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 7/26/1880			6. AGE (In years last birthday) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH CARROLL Md.					
10. CITY OR TOWN OF DEATH SYKESVILLE			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PULLEN NURSING HOME			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) SALESMAN			12b. KIND OF BUSINESS OR INDUSTRY Clothing		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN RANDALLSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 8811 FLAGSTONE DRIVE		
14. FATHER'S NAME First Middle Last BIRCKHEAD ROUSE				15. MOTHER'S MAIDEN NAME First Middle Last Henrietta -- Shermer							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) no				16b. SOCIAL SECURITY NO. 212-01-4469		17. INFORMANT Address Randallstown, Md. Joseph Rouse, 8811 Flagstone Drive,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> 20 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 13, 1967</u> to <u>Oct 29, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Oct 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Sani Okutman MD				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 10.29.68			
22d. PHYSICIAN'S NAME (Type) Sani Okutman				22e. ADDRESS Sykesville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Oct. 31, 1968		23c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial Cemetery				23d. LOCATION (City or Town) (County) (State) Abingdon Harford Md			
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.				ADDRESS		25a. NEED REGISTRAR DATE OCT 31 1968		25b. REGISTRAR'S SIGNATURE J Charles Judge			

14377

UNITED STATES GOVERNMENT

OFFICE OF THE SECRETARY

MEMORANDUM FOR THE SECRETARY

SUBJECT: [Illegible]

DATE: [Illegible]

FROM: [Illegible]

TO: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
14269					14278					
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>Sadie May Schaeffer</b>					2a. DATE OF DEATH Month <b>10</b> Day <b>28</b> Year <b>68</b>			2b. HOUR <b>1:45 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH		6. AGE (In years last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll.</b>				
10. CITY OR TOWN OF DEATH <b>Manchester, md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Longview Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution) STATE <b>md.</b>			13b. COUNTY <b>Carroll.</b>		13c. CITY OR TOWN <b>Snydersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Route #3 Bx 184 Westminster md.</b>	
14. FATHER'S NAME First <b>William</b> Middle <b>Zipp</b> Last <b>Carroll</b>			15. MOTHER'S MAIDEN NAME First <b>Carrie</b> Middle <b>Sprinkle</b> Last <b>Carroll</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no.</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-16-0438</b>		17. INFORMANT <b>Edna Shaffer (daughter)</b> Address <b>346 N. Main St. Hampstead, md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4369</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>General arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>3 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (1) (this hospital) attended the deceased from <b>1961</b> , to <b>Oct 28</b> , 19 <b>68</b> , that (1) (we) last saw the deceased alive on <b>Oct 26</b> , 19 <b>68</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.										
22b. SIGNATURE <b>W H Foard M.D</b>				DEGREE <b>M.D</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>W. H Foard M.D</b>				22e. ADDRESS <b>Manchester, md 21102</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Snydersburg Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hampstead Carroll Md.</b>				
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>		

143318

RECEIVED

1951

1951

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14270					14279						
1. DECEASED-NAME (Type or print)					2a. DATE OF DEATH						
Sarah					10 Month 27 Day 68 Year						
3. SEX					2b. HOUR						
female					4:25 PM						
4. RACE			5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS		
white			8-1885			83 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Russia			U.S.A.						Carroll Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Rural--Sykesville			Springfield State Hospital			HOUSEWIFE AT HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
CALIF.			HOLLYWOOD			YES			7273 FOUNTAIN AVE		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last ? ? Lichtenstein			First Middle Last unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT					
no			220-54-7135J			MRS. REBEKAH KLEIN 7273 FOUNTAIN AVE, HOLLYWOOD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Arteriosclerotic heart disease										Years	
DUE TO, OR AS A CONSEQUENCE OF											
(b) Severe coronary arteriosclerosis										Years	
DUE TO, OR AS A CONSEQUENCE OF											
(c) Bilateral bronchopneumonia										Days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
Schizophrenic reaction, paranoid type.											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 9/14/1918, to 10/27/1968, that (X) (we) last saw the deceased alive on 10/27/1968, and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
Renato R. Espina			10/27/68			Renato R. Espina, M. D.			Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL			10-29-68			BALTIMORE HEBREW			BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD						DATE OCT 30 1968			J Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14271												DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												14280			
1. DECEASED-NAME (Type or print) First Middle Last DANA W. Sparks												2a. DATE OF DEATH Month Day Year Oct 4 1968												2b. HOUR 12:30 M			
3. SEX female				4. RACE white				5. DATE OF BIRTH 11/20/1987				6. AGE (In years last birthday) 80 YRS.				IF UNDER 1 YEAR MONTHS DAYS				IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Carroll Md															
10. CITY OR TOWN OF DEATH Manchester				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Long View Nurs Home				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse				12b. KIND OF BUSINESS OR INDUSTRY Nurse															
13a. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE Md				13b. COUNTY Carroll				13c. CITY OR TOWN Westminster				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET AND NUMBER RFD 5											
14. FATHER'S NAME First Middle Last Theophilus Woody				15. MOTHER'S MAIDEN NAME First Middle Last Cecile Riddick																							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No				16b. SOCIAL SECURITY NO. 245-363299				17. INFORMANT Maude Higgins				Address Westminster Md															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 4369 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> 5x1-5. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 weeks															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 331x																											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?															
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a. I certify that (I) (this hospital) attended the deceased from 9/4, 1968, to 10/4, 1968, that (I) (we) last saw the deceased alive on Oct 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																											
22b. SIGNATURE W H Foard M.D.				DEGREE M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED 10/4/68															
22d. PHYSICIAN'S NAME (Type) W H Foard M.D.				22e. ADDRESS 25 N. Main St Manchester Md 21102																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE 10/8/68				23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery				23d. LOCATION (City or Town) (County) (State) Burnsville N.C.															
24. FUNERAL DIRECTOR J. E. Myers, Jr., Westminster, Md.				ADDRESS				25a. REC'D BY REGISTRAR DATE OCT 7 1968				25b. REGISTRAR'S SIGNATURE Charles Judge															

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UNITED STATES OF AMERICA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14272		CERTIFICATE OF DEATH						14281			
1. DECEASED-NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH	2b. HOUR	
CHESTER			W.		STALEY				OCTOBER 14, 1968	6:30A M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		5-3-1891			77 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		Md.		
Maryland		U.S.A.					Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield State Hospital			Farmer					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rural		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
David			F.		Staley				Cecilia C. Stull		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			219-46-3642		Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Abscess of right hemisphere of the brain/485X										Days or weeks	
DUE TO, OR AS A CONSEQUENCE OF unknown origin											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Bronchopneumonia, both bases of lungs										Days	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
491X											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 12-9-23, 19__, to 10-14-68, 19__, that (I) (we) last saw the deceased alive on 10-14-68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22c. DATE SIGNED		
Octavio A. Ruiz, M.D.									10-14-68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
Octavio A. Ruiz, M. D.			Springfield State Hospital			Sykesville, Maryland 21784					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		10-17-68		Mt. Olivet Cemetery		Frederick, Frederick Co., Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
John H. Bast, Jr.			1112 N. Main St.			Boonsboro, Md.			OCT 18 1968 Charles Judge		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

14273

14282

1. DECEASED-NAME (Type or print) <b>Carolyn Rebecca Sullivan</b>			2a. DATE OF DEATH Month <b>OCT</b> Day <b>31</b> Year <b>68</b>			2b. HOUR <b>2:10</b> M <b>A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>SEPT. 16, 1879</b>		6. AGE (In years last birthday) <b>89</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>CARROLL CO.</b> Md.	
10. CITY OR TOWN OF DEATH <b>SYKESVILLE, RD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>KLEES MILL GUEST HOME</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>13 W. GEORGE ST.</b>		14. FATHER'S NAME First <b>ABSALOM</b> Middle <b>REESE</b> Last <b>ALICE VIRGINIA STANSBURY</b>		15. MOTHER'S MAIDEN NAME First <b>ALICE VIRGINIA STANSBURY</b> Middle <b>ALICE VIRGINIA STANSBURY</b> Last <b>ALICE VIRGINIA STANSBURY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service) <b>-</b>	
16b. SOCIAL SECURITY NO. <b>212-01-8688-D</b>		17. INFORMANT <b>MRS EVELYN WAGNER MTAIRY, MD.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure, ASHD</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis, generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arrhythmia fibrillation, Renal insufficiency.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>Sept. 1967</b> <b>Oct. 1968</b>		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4341</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State		22a. I certify that (I) (this hospital) attended the deceased from <b>Sept. 1967</b> , to <b>31 Oct. 1968</b> , that (I) (we) last saw the deceased alive on <b>31 Oct. 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
22b. SIGNATURE <b>Howard E. Hall</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Oct. 31, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Howard E. Hall, M.D.</b>		22e. ADDRESS <b>Sykesville, Maryland</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			
23b. DATE <b>11/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KRIDERS CEMETERY WESTMINSTER RD., MD.</b>		23d. LOCATION (City or Town) (County) (State) <b>WESTMINSTER, MD.</b>		24. FUNERAL DIRECTOR <b>J. E. Meyer, Jr., Westminster, Md.</b>	
25a. REC'D BY REGISTRAR <b>NOV 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 17-64  
30M REV. 4-68

14274				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				14283			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <b>Sylvia Katherine Valentine</b>				2a. DATE OF DEATH 10 Month 11 Day 68 Year				2b. HOUR 3:15 PM			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>8/3/1900</b>		6. AGE (In years last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.					
10. CITY OR TOWN OF DEATH <b>Rural--Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Mt. Savage</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>none</b>			
14. FATHER'S NAME First Middle Last <b>Samuel Trost</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Bertha Crawford</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>214-07-1263</b>		17. INFORMANT Address <b>Springfield Hospital records, Sykesville, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201</b> (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Schizophrenic reaction, chronic undifferentiated type. Mental deficiency.</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>8/21/1968</b> , to <b>10/11/1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/11/1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Naci N. Buyukunsal, M. D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>10/11/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Naci N. Buyukunsal, M. D.</b>				22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland</b>							
23a. BURIAL, CREMATION, or other disposition (Specify) <b>Burial</b>		23b. DATE <b>Oct. 13, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mt. Savage, Md.</b>					
24. FUNERAL DIRECTOR <b>James F. Searpelli, Cumberland, Md.</b>				ADDRESS <b>Springfield Hospital records, Sykesville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

14283

UNITED STATES DEPARTMENT OF AGRICULTURE

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UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
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UNITED STATES DEPARTMENT OF AGRICULTURE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
14275										
14284										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR P M	
LILLIAN			MARIE			WADE			OCTOBER 28, 1968	3:00 P
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
Female		White		9-2-1895		73 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.	
Maryland		U.S.A.				Carroll				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville		Springfield State Hospital		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Frederick		Brunswick				601 W. Potomac St.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
George Forest			Sarah Koontz							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No		Unk.		Records, Springfield State Hospital						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>										Days
4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u>										Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Carcinoma of urinary bladder</u>										Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4200										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>8-19-68</u> , 19 <u>  </u> , to <u>10-28-68</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>10-28-68</u> , 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Agustin del Campo, M.D.</u>					DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-28-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M. D.</u>					22e. ADDRESS <u>Springfield State Hospital</u> <u>Sykesville, Maryland 21784</u>					
23a. BURIAL, CREMATION, REBURYAL (Specify)		23b. DATE <u>10/31/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>			23d. LOCATION (City or Town) (County) (State) <u>Sharpsburg Wash. Md.</u>			
24. FUNERAL DIRECTOR <u>Frederick Funeral Home</u>					ADDRESS		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14034

RECEIVED 10/10/1961

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14276

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14285

1. DECEASED-NAME (Type or print) <i>CORINNE Dorothy</i>			First Middle Last			2a. DATE OF DEATH <i>Oct</i> Month <i>9</i> Day <i>1968</i> Year			2b. HOUR <i>11:45</i> MIN. <i>P</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH <i>Feb 9-1909</i>			6. AGE (In years last birthday) <i>59</i> YRS.		
7a. BIRTHPLACE (State or foreign country) <i>Carrroll Co</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Carrroll</i> Md.		
10. CITY OR TOWN OF DEATH <i>Manchester RFD 1</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>RFD 1</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <i>STATE Maryland</i>			13b. COUNTY <i>Carrroll</i>			13c. CITY OR TOWN <i>Manchester</i>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <i>RFD 1</i>			14. FATHER'S NAME First <i>Milton</i> Middle <i>H</i> Last <i>Heese</i>			15. MOTHER'S MAIDEN NAME First <i>MARY</i> Middle <i>Yingling</i> Last <i>Yingling</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>340X</i>			17. INFORMANT <i>Ross Weaver</i> Address <i>Manchester, Md</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multiple Sclerosis</i> <i>340X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>345X</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 1968</i> , to <i>Oct 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>Sept 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE <i>W H Foard M.D</i>			22c. DATE SIGNED <i>10/9/68</i>			22d. PHYSICIAN'S NAME (Type) <i>W. H Foard M.D.</i>			22e. ADDRESS <i>Manchester, Md 21102</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>10/12/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Miller Memorial Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Manchester Md Carrroll Co</i>		
24. FUNERAL DIRECTOR <i>Wayne V. Kenworthy</i>			ADDRESS <i>Harrover Penna</i>			25a. REC'D BY REGISTRAR <i>Charles Judge</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		
DATE <i>OCT 16 1968</i>											

14382

CERTIFICATE OF ANALYSIS

1-17

1-17-1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
JOHN CLIFFORD WHITTINGTON						OCTOBER 14, 1968		5:45P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		10-3-1890		78 YRS.				
7a. BIRTHPLACE (State or foreign county)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> <del>SEPARATED</del>		9. COUNTY OF DEATH				
Pennsylvania		U.S.A.				Carroll Md.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Sykesville		Springfield State Hospital		Coal Miner						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore City		Baltimore				721 S. Broadway	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Charles Edward Whittington			Ella Mae Milligan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
Yes WWI 1917-18			189-10-6806		Records, Springfield State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myelogenous leukemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>2050</u> (c) <u>2043</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Weeks	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>CBS assoc. with cerebral arteriosclerosis, with psychotic reaction. Chronic alcoholism.</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-59</u> , 19____, to <u>10-14-68</u> , 19____, that (I) (we) last saw the deceased alive on <u>10-14-68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Octavio A. Ruiz M.D.</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>					22c. DATE SIGNED <u>10-15-68</u>					
22d. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M. D.</u>					22e. ADDRESS <u>Springfield State Hospital Sykesville, Maryland 21784</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		10-18-68		Mt. Vernon Cemetery		Buena Vista, Pa.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Ellsworth Armacost 4600 Liberty Hghts. Ave.					OCT 16 1968		<u>[Signature]</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

14287

1. DECEASED-NAME (Type or print) First Middle Last <b>CLAUDE (NMN) WOLF</b>			2a. DATE OF DEATH Month Day Year <b>OCTOBER 17, 1968</b>		2b. HOUR A M <b>4:25</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>11-22-01</b>		6. AGE (In years last birthday) <b>66</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springfield State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>	
13c. CITY OR TOWN <b>Westminster</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rural - Rt. 3</b>	
14. FATHER'S NAME First Middle Last <b>Unk.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Unk.</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Unk.</b>		16b. SOCIAL SECURITY NO. <b>217-12-1363-4</b>		17. INFORMANT Address <b>Records, Springfield State Hospital</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> <b>433.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>332.2</b> (b) <b>Generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Chronic brain syndrome assoc. with cerebral arteriosclerosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-24-68</b> , 19____, to <b>10-17-68</b> , 19____, that (I) (we) last saw the deceased alive on <b>10-17-68</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Octavio A. Ruiz</b>		22c. DATE SIGNED <b>10-17-68</b>		22d. PHYSICIAN'S NAME (Type) <b>Octavio A. Ruiz, M. D.</b>	
22e. ADDRESS <b>Springfield State Hospital Sykesville, Maryland 21784</b>		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22g. REC'D BY REGISTRAR <b>DATE OCT 18 1968</b>	
22h. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		22i. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22j. LOCATION (City or Town) (County) (State) <b>Silver Run, Carroll Co., Md.</b>	
22k. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22l. DATE <b>10/19/68</b>		22m. FUNERAL DIRECTOR <b>Richard A. Little</b>	
22n. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22o. ADDRESS <b>Littlestown, Pa.</b>		22p. DATE <b>OCT 18 1968</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

14278

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14288

1. DECEASED-NAME (Type or print) <b>Lillian Adelaide Zepp</b>			2a. DATE OF DEATH <b>Oct.</b> Month <b>20</b> Day <b>1968</b> Year			2b. HOUR <b>10A</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 9, 1909</b>		6. AGE (In years at birth) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>York Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b>			Md.
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Carroll Co. Hospt.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Balto.</b>		13c. CITY OR TOWN <b>Upperco</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Trenton Rd.</b>	
14. FATHER'S NAME First Middle Last <b>Harrison LaMott</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Hazel Sapp</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>212-28-6384</b>		17. INFORMANT Address <b>L. Russell Zepp Upperco, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Refractory Congestive heart failure</b> <b>398x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Rheumatic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>50 yrs.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <b>416x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct 9, 1968</b> , to <b>Oct 20, 1968</b> , that (I) (we) last saw the deceased alive on <b>Oct 20, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>John S. Harshey, MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>10/20/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN S. HARSHEY, M.D.</b>		22e. ADDRESS <b>8 Ardian St. Westminster, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Oct. 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hampstead Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hampstead Carroll Co. Md.</b>			
24. FUNERAL DIRECTOR <b>Tipton - Eline Funeral Home Hampstead, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR DATE <b>OCT 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Phyllis Jones</b>	

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STATE OF NEW YORK

1938

IN SENATE

January 1, 1938

REPORT

OF THE

COMMISSIONER

OF THE

DEPARTMENT OF

LABOR AND INDUSTRY

FOR THE YEAR

ENDING DECEMBER 31, 1937

ALBANY

1938

PRINTED BY THE STATE OF NEW YORK

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